World Health Organization
REGIONAL OFFICE FOR Europe

Report on the **health of refugees and migrants** in the WHO European Region

No PUBLIC HEALTH without REFUGEE and MIGRANT HEALTH

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Foreword

Population movement is one of the defining phenomena of our time. In today's world, marked by economic inequalities, easily transmissible information and ease of travel, more people readily move in search of better living conditions for themselves and their families.

There is a steady increase in the global number of refugees and migrants, including in the WHO European Region. Globally, in 2017, 258 million people (approximately one in every 30) lived outside their country of origin. In the WHO European Region, almost 10% of the population of almost 920 million are international migrants, accounting for 35% of the global international migrant population.

Work is a major reason that people migrate internationally, and migrant workers constitute a large majority of the world's international migrants. Violence, conflicts, natural disasters and human rights abuses also force many to move from their normal place of residence. The Office of the United Nations High Commissioner for Refugees (UNHCR) reports the highest level of human displacement ever, with some 68.5 million people being forced from their homes. The number of refugees is estimated to be more than 25 million.

Obtaining a true picture of the health profile of refugees and migrants and of the health system responses through regional standardized data collection and sharing, open policy dialogue and commitment is paramount in achieving the vision of Health 2020, the Sustainable Development Goals and universal health coverage.

The Report on the Health of Refugees and Migrants in the WHO European Region is the first WHO report of its kind, creating an evidence base with the aim of supporting evidence-informed policy-making to meet the health needs of refugees and migrants and the health needs of the host populations.

Today, our political and social structures often struggle to rise to the challenge of responding to displacement and migration in a humane and positive way. Yet the relationship between displacement, migration and development, including health, has become more prominent recently in international and regional policy agendas, and it has emerged as a theme of common interest for all Member States.

In 2016, the WHO Regional Committee for Europe adopted the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region to help to guide progress on the health aspects of population movement. Globally, the WHO Executive Board in 2017 adopted the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants.

In addition, and with the aim of harmonizing refugee and migrant health policy globally, WHO is now preparing a global action plan on the health of refugees and migrants, in line with the health dimensions of the United Nations Global Compact on Safe, Regular and Orderly Migration and the Global Compact for Refugees, in close collaboration with the International Organization for Migration, UNHCR, other partner international organizations, Member States and other relevant stakeholders, as well as refugees and migrants themselves.

Refugees and migrants enjoy the same human right to health as everyone else. One key priority is enhancing social protection for refugees and migrants, including developing sustainable financial mechanisms, both nationally and internationally, to provide for universal health coverage and social protection. Another key priority is reducing the xenophobia, discrimination and stigma often experienced by refugees and migrants, through actions such as advocacy and evidence-informed communication with both refugee and migrant communities and host populations.

These high principles provide the background to this report, which shows the progress made so far in responding to these health challenges, and what more needs to be done. I am delighted that the WHO European Region has led the way, and I hope that this report will inspire yet more progress in the coming months and years.

Zsuzsanna Jakab
WHO Regional Director for Europe

A note from the Programme Coordinator

Displacement and migration has always been a reality for the WHO European Region and the contribution of refugees and migrants, alongside host populations, in developing the societies in which we currently live should not be forgotten. At the same time, the challenges faced by refugees and migrants must also be acknowledged. The lives that are being lost in the Mediterranean Sea and other places in the Region are a painful and constant reminder of the many challenges that refugees and migrants face on a daily basis.

The WHO Regional Office for Europe is very much aware of these challenges and is taking preventive and proactive measures to address the public health aspects of migration. By establishing the first WHO Migration and Health programme, the Regional Office has increased its support for its Member States in developing robust and refugee and migrant-sensitive health systems to make migration a positive experience for all stakeholders involved. New ground has been broken in many ways by the programme to support Member States. Joint assessments with Member States have examined health system capacity to manage influxes of refugees and migrants. Evidence overviews have been produced to inform policy-making, and high level meetings and schools have disseminated knowledge and raised awareness. All these activities have led to the development and adoption of the first ever WHO regional strategy and action plan for refugee and migrant health. This is helping the Region to have a common framework to promote refugee and migrant health using high-quality evidence and intersectoral action. Progress has been achieved in several Member States in making refugee and migrant health part of mainstream health policies through the implementation of the Strategy and Action Plan, although much more needs to be done. The programme has been instrumental in supporting countries and institutions to promote refugee and migrant health in the Region and beyond.

One of the main challenges faced by the Migration and Health programme and the Member States in developing a robust refugee and migrant-sensitive health system was the lack of an overview of refugee and migrant health in the Region. The decision to produce this report was one of several measures taken to address this challenge. It is of paramount importance to consolidate and disseminate evidence not only to inform policies but also to counter myths. For example, it is often said that there are "a lot of refugees in the Region". Data presented in the report show that international migrants make up only 10% of the total population residing in the Region and less than 7.4% of these international migrants are refugees. Another so-called fact often stated is that the refugees and migrants bring communicable diseases to the Region. However, this is not always true. For example, evidence presented in the report shows that a significant proportion of the refugees and migrants who are HIV positive acquire infection after they have arrived in the Region, including those who have moved from countries with high HIV endemicity.

The fruitful partnership with the the Italian National Institute for Health, Migration and Poverty (INMP) has enabled us to produce the report with the best available data. The data collection process for developing the report was revealing as it showed the extent of data on refugee and migrant health that is available and not available, providing further impetus to progress implementation of the Strategy and Action Plan.

The Migration and Health programme is very proud to present the report as a first step in generating Region-wide evidence on refugee and migrant health and we hope that you enjoy reading the report.

Santino Severoni
Coordinator, Migration and Health programme

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Abbreviations

AMR	antimicrobial resistance
CI	confidence interval
EEA	European Economic Area
EU	European Union
HBV	hepatitis B virus
HCV	hepatitis C virus
ILO	International Labour Organization
IOM	International Organization for Migration
MDR-TB	multidrug-resistant tuberculosis
NCD	noncommunicable disease
NGO	nongovernmental organization
PHAME	Public Health Aspects of Migration in Europe (now the Migration and Health programme)
PTSD	post-traumatic stress disorder
SDG	Sustainable Development Goal
STI	sexually transmitted infection
TB	tuberculosis
UNHCR	Office of the United Nations High Commissioner for Refugees

Executive summary

The 53 countries of the WHO European Region have a population of almost 920 million, representing nearly a seventh of the world's population; international migrants make up almost 10% (90.7 million) in the Region and account for 35% of the global international migrant population (258 million). The proportion of international migrants, including refugees, in Member States of the Region varies from more than 50% in Andorra and Monaco to less than 2% in Albania, Bosnia and Herzegovina, Poland and Romania. As a consequence, displacement and migration-related programme and policy priorities may vary between Member States. Yet, every country today can be an origin, transit or a destination country for refugees and migrants, sometimes acting as more than one of these. As a result, the health of refugees and migrants has progressively emerged as a theme of common interest for all Member States. At present, there are no global or region-wide indicators or standards for refugee and migrant health, and no global or regional framework is currently implemented for the standardized and routine collection of data. This leads to a shortage of scientifically valid and comparable health data on refugee and migrant populations.

Across the WHO European Region, there are fundamental differences in the way health services are organized, financed and governed for the population as a whole, with health policies for refugees and migrants adding a further layer of complexity. Differences exist between countries in access requirements to health services and the level of implementation of regionally agreed strategies, recommendations and policies, particularly for migrants in an irregular situation (irregular migrants). In general, regional health policies recommend or define that emergency and urgent care should be available to all refugees and migrants throughout the Region, regardless of legal status.

Improving health for all and reducing health inequalities are key parts of many WHO strategies, action plans and frameworks, both globally and regionally. This report is intended to create an evidence base to aid Member States of the WHO European Region and other national and international stakeholders in promoting refugee and migrant health by implementing the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, which incorporates the priority areas listed in Health 2020, the WHO European Region's policy framework for the promotion of equitable health and well-being.

Health profile of refugees and migrants in the WHO European Region

Refugee and migrant health is a highly complex topic and research findings often cannot be generalized to wider refugee and migrant populations in a country, in a region or globally. The effects of the migratory process, social determinants of health and the risks and exposures in the origin, transit and destination environments interact with biological and social factors to create different health outcomes.

Mortality estimates tend to be lower in refugees and migrants than in the European host population for all-cause mortality, neoplasms, mental and behavioural conditions, injuries, endocrine conditions and digestive conditions. Summary standardized mortality ratios are estimated to be higher for infections, external causes, diseases of the blood and blood-forming organs and cardiovascular diseases. Refugees and migrants can be vulnerable to infectious diseases because of lack of health care or interrupted care in the country of origin, because of exposure to infections and lack of care in transit, and if living conditions are poor in the destination country.

There are indications that there is a very low risk of transmitting communicable diseases from the refugee and migrant population to the host population in the WHO European Region. It is possible that refugees and migrants arriving from countries with a high prevalence of tuberculosis (TB) might reflect a similar prevalence. However, the proportion of refugees and migrants among a country's TB cases varies from more than 90% to less than 1%, reflecting the prevalence in the host country. The same is true for HIV. A significant proportion of those refugees and migrants who are HIV positive acquire infection after they have arrived in the Region, and they are more likely to be diagnosed later in their HIV infections. Infections with hepatitis B virus (HBV) and hepatitis C virus (HCV) are more common among refugees and migrants arriving from countries with high endemic disease, but prevalence

of these infections among refugee and migrant populations varies across the Member States of the Region. Tropical and parasitic infections that are not normally seen in Europe may enter the Region via refugees, migrants and travellers originating from or visiting areas of higher endemicity.

Research indicates that the duration of stay in the host country within the WHO European Region can be positively associated with an increase in risk for a non-communicable disease (NCD) such as cardiovascular diseases, stroke or cancer. Although, generally, there is a higher risk of ischaemic heart disease and stroke among the refugee and migrant population, there is no clear pattern for cardiovascular diseases and prevalence may be linked as much to socioeconomic factors as to migration-specific factors. Refugees and migrants have a lower risk for all neoplasms except cervical cancer, for which they are also more likely to be diagnosed at a later stage in their disease than the host populations in the Region. In general, refugees and migrants in the Region have a higher incidence, prevalence and mortality rate for diabetes than the host population, with higher rates seen in women than men depending on the country of origin.

Prevalence of mental disorders in refugees and migrants shows considerable variation depending on the population studied and the methodology of assessment. Risk factors for mental health problems may be experienced during all phases of the migratory process and in settling in the host country. Post-traumatic stress disorder (PTSD), mood disorder and depression are the most frequently reported conditions among international migrants, mainly for refugees and recently arrived asylum seekers. However, the evidence is not conclusive and there is a wide range in the reported prevalences. For example, the reported prevalence of depression in the refugee and migrant population varied from 5% to 44%, compared with a prevalence of 8–12% in the general population. Poor socioeconomic conditions, such as unemployment or isolation, are associated with increased rates of depression in refugees after resettlement. Migration was also found to be a risk factor for children's mental condition, and unaccompanied minors experience higher rates of depression and symptoms of PTSD compared with other refugee and migrant groups.

Labour migrants constitute the largest group of migrants globally. Around 12% of all workers in the Region were migrants in 2015. Conditions of employment vary drastically as do the health hazards of the jobs and the access to social and health protection. Male migrants experience significantly more work-related injuries than non-migrant workers, whereas rates for female migrants appear to be similar to those of the host population.

For female refugees and migrants, there is a marked trend for worse pregnancy-related indicators. However, refugee and migrant women can be protected from adverse obstetric and perinatal health outcomes through personal factors such as socioeconomic and educational status and characteristics of the host country (e.g. having a strong integration policy). Knowledge of family planning is varied among refugees and migrants, and in general they may also lack awareness of available health support. Sexual violence can occur for refugees and migrants in transit settings and in countries of destination, creating increased vulnerability to sexually transmitted infection (STI).

Refugee and migrant children may be more prone to health issues related to diet, both malnutrition and overweight/obesity. As noted above, migration is also a risk factor for mental disorders in children.

Utilization of primary care services by refugees and all categories of migrant is affected by the organization of the health system and whether payments are required for access. Preventive care includes both measures that prevent ill health (e.g. immunization and health education) and those that detect ill health at an early stage so that treatment can be introduced when it works best (e.g. screening and health checks). Provision of ethical and effective screening and health care for migrants at borders is an important step towards ensuring the health needs of refugees and migrants moving on into host communities.

Towards a refugee and migrant-friendly health system and universal health care in the WHO European Region

Reflecting World Health Assembly resolution WHA 61.17 in 2008 and the subsequent global consultation in Madrid in 2010, the WHO Regional Office for Europe engaged with Member States, partner organizations and other stakeholders in advancing and implementing identified refugee and migrant health strategies and priorities. Important aspects of this work included

both support to integrate the health needs of refugees and migrants into national health strategies, policies and programmes of Member States and assistance in scaling up preparedness and response in relation to the complex crisis and mixed flows of refugees and migrants from the Middle East and north Africa that emerged in 2011. Critical to these activities was adoption of Health 2020 by the 62nd session of the WHO Regional Committee for Europe in 2012 and other major regional policy frameworks aimed at facilitating and supporting universal, sustainable, high-quality, inclusive and equitable health systems. Health 2020 drew particular attention to displacement, migration and health, as well as issues of population vulnerability and human rights, and has provided a comprehensive foundation for public health work in the Region. Furthering the work done within this area, a High-level Meeting on Refugee and Migrant Health in the WHO European Region was held in Rome in 2015, where Member States agreed on the need for "a common framework for collaborative action on refugee and migrant health, acting in a spirit of solidarity and mutual assistance, to promote a common response, thereby avoiding uncoordinated single-country solutions". The Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region was adopted the following year at the 66th session of the Regional Committee for Europe in 2016. The implementation of the Strategy and Action Plan is periodically followed up by the WHO Regional Office for Europe. The results of the first follow-up survey are reported in Chapter 3.

The influx of refugees and migrants into the WHO European Region since 2015 has come in a series of repeated waves encompassing from tens to several hundreds of refugees and migrants, often simultaneously in different areas, and increasing significantly in frequency during the summer months. The speed and conditions with which these mobile populations arrived, and the number of people involved, created challenges for the countries receiving them. Refugees and migrants with pre-existing conditions or ones that they were unaware of (e.g. cardiovascular diseases, diabetes, pregnancy or malignancies) might not have had access to medical attention or treatment before or during their travel and arrive needing treatment. Apart from complications arising from lack of care, common infections acquired during displacement and migration and lack of nutrition can worsen these conditions. This necessitates identification of the problem and possibly intensive care on arrival. A commonly encountered problem relates to the integration of general medical services, psychosocial services and protection. Vulnerable or traumatized individuals (e.g. victims of trafficking and gender-based violence, victims of torture and trauma, and unaccompanied or orphaned minors) often have both physical and mental disorders. Uncertainty or insecurity related to the outcome of asylum claims, housing, family separation, employment prospects and future expectations all impact the health of new arrivals regardless of prior traumatization.

To gain further knowledge of the Member States health systems and their current integration of the Strategy and Action Plan, a survey was conducted in 2018. This first survey of Member States revealed progress in strategic planning and policy development to meet the health needs of refugees and migrants in the Region. A national focus on advocating for a rights-based and multisectoral approach to health was reported by more than half of the 40 responding Member States and was only slightly exceeded by attention to the issue of communicable diseases. There is a lack of reliable, comparable and nationally representative data on refugee and migrant health and one reason for this is that refugee and migrant health-related variables are not commonly included in national datasets: only 20 of the 40 Member States responding to the survey included these variables in their national datasets.

Way forward: a vision for the health of migrants and refugees in the WHO European Region

The development of a comprehensive refugee and migrant health agenda needs to encompass aspects for both the long-term, structural and widespread presence of refugees and migrants within communities (whether regular or irregular) and the acute sudden arrivals of mixed flows. The development or adaptation of policies and plans should preferably build on national population-based health strategies and be coherent with country-specific refugee and migrant profiles. At both the national and the local decentralized levels of the health system, it is important to enhance stewardship for implementation of the Strategy and Action Plan. This entails identifying and mandating designated officials, services or departments to lead and ensure accountability and consolidation of achievements during the scaling-up phase of the Strategy and Action Plan. Lack of a defined health sector stewardship can lead to fragmentation and poor accountability.

Refugees and migrants are entitled to the same universal human rights and fundamental freedoms as all people, which must always be respected, protected and fulfilled. However, refugees and migrants are distinct groups governed by separate legal frameworks. Only refugees are entitled to specific international protections defined by international refugee law. The term migrant is all embracing and lends itself to varied interpretations. The fact is that various categories of migrant might have very diverse health needs and outcomes, depending on a plethora of individual and process-related factors. There are two aspects related to policies to consider in refugee and migrant health. The first concerns the explicit adoption or application of policies that specifically ensure equity and coverage for various migrant groups. Associated with this mainstream strategy is the inclusion of an explicit reference to refugees and migrants within general population-based or disease-specific health policies. The second aspect is to ensure that policies in other sectors do not cause adverse health outcomes for refugees and migrants. This complex endeavour is better achieved when the health sector ensures stewardship, promotes the observance of fundamental health principles and engages in constructive multisector dialogues, not only domestically but also regionally and globally. Global policy instruments and multilateral agreements can at times be important in driving a more stringent domestic policy coherence. A major challenge is represented today by xenophobia, often explicit racism, and sovereignty issues that risk setting back currently achieved progress. Delivering high-quality health care to those who need it most is one of the basic components of global health. To complete that task, accurate and relevant health information is required to support evidence-informed policy planning and development. At the same time, the complexity and diversity of modern displacement and migration will demand that any empirical approach to address refugee and migrant health issues in future is founded on accurate and reliable information.

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CHAPTER 1

Overview of refugee and migrant trends and health policies in the WHO European Region

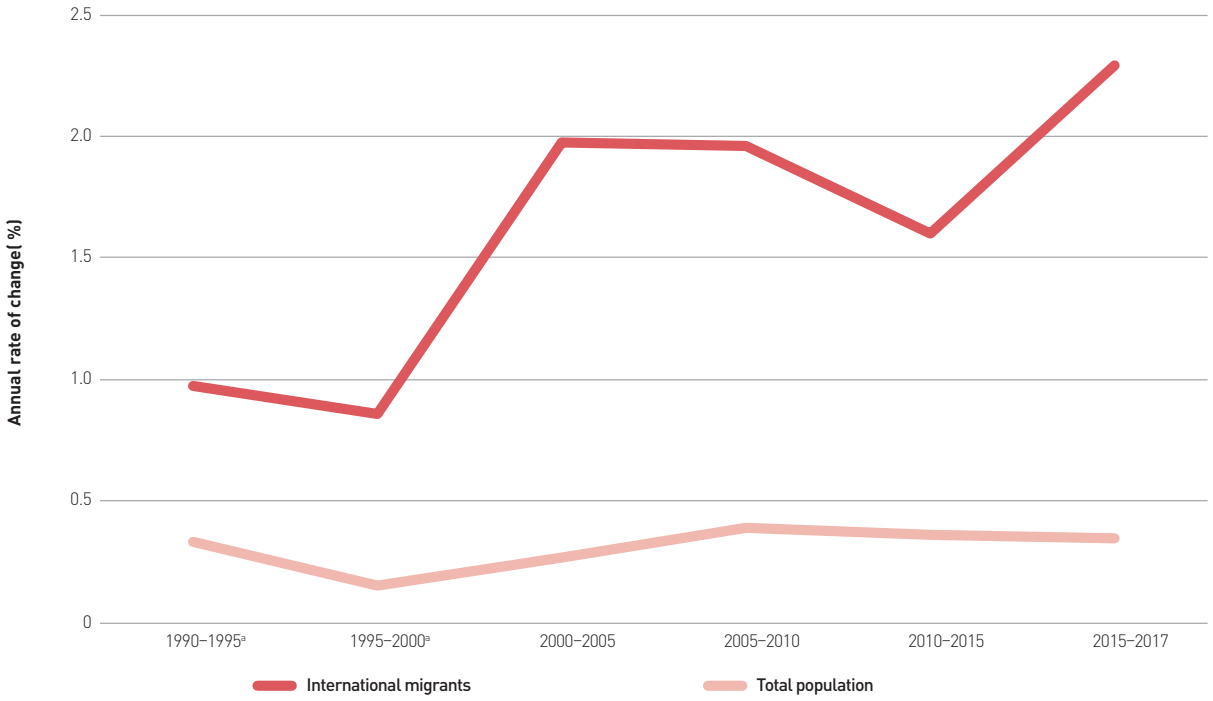
Introduction

While population displacement and migration has always been salient aspects of human societies, it is since the mid-2000s that its health aspects have grown in the attention of the 53 Member States of the WHO European Region. In 2017, there were more than 90 million international migrants living in the Region, amounting to almost 10% of the total population of the Region and 35% of the global international migrants *(1)*. There is wide variation among Member States in both the proportion of international migrants in the country (e.g. 45% in Malta and less than 2% in Albania; Annex 1) and in the refugee and migration-related health policy priorities and systems. For many countries, displacement and migration are major aspects of population dynamics, and Member States may concurrently act as places of origin, transit and/or destination for refugees and migrants. Additionally, many Member States are seeing a significant increase in the number of refugees and migrants against a much slower change in the host population, reflecting declining birthrates and ageing populations (Fig. 1.1). International migrants can, therefore, often help to fill the labour needs of the host country. Labour migrants form the largest group globally *(2)*.

Since the late 2000s, the WHO European Region has experienced an influx of refugees and migrants, with a rapid increase occurring in 2015. Much attention has focused on those refugees and migrants fleeing to Europe, with thousands losing their lives in the attempt. It is estimated that more than 50 000 individuals have lost their lives from the beginning of the millennium in the Mediterranean alone *(3)*. Many of these refugees and migrants are fleeing from instability caused by conflicts, violence, natural disasters and human rights abuse. However, many also migrate for reasons such as family reunification, to study and to look for work.

While many refugees and migrants are young adults, an increasing number of elderly and disabled people as well as an increasing number of minors, many unaccompanied, are among the recently arrived refugees and migrants in the Region *(4)*. Women, including

Fig. 1.1. Annual rate of change of the international migrant stock and total population of the WHO European Region, 1990–2017



[a]Data are not available for Montenegro.

Source: United Nations Department of Economic and Social Affairs, 2017 *(1)*.

pregnant women, made up more than half of all refugees and migrants living in the Region in 2017 *(1)*. Women are often disproportionately represented in vulnerable groups, such as victims of gender-based violence, human trafficking and sexual exploitation.

Heterogeneity in terminology regarding migrants unlike in the case of refugees

The term **refugee** is defined precisely in the 1951 Convention relating to the Status of Refugees and the 1967 Protocol thereto *(5)*. Migrants are a heterogeneous group consisting of categories such as irregular migrants, unaccompanied minors and labour migrants. There are no universally accepted definitions for a migrant at an international level, with definitions varying by length of stay in a country, documentation/residency or reason for migration *(6)*. It is also apparent that a migrant does not have a clearly defined status for life: an asylum seeker becomes a refugee once the application has been approved but an irregular migrant if it is denied and the migrant continues to stay in the country without a valid travel document and permit to stay; and a migrant can lose legal status and become irregular because of moving from being a child to an adult, losing employment or exceeding a defined length of stay. However, placing migrants into a defined subgroup can have an impact on their entitlement to affordable and adequate health services and their ability to access these services, with national legislation regarding entitlement varying among Member States *(6)*. The heterogeneity of concepts and definitions of migrant is also a barrier to deriving evidence to inform public health care policies. Box 1.1 lists the main groupings as discussed in this report (see

Box 1.1. Definitions of refugees and migrants used in this report

This report uses the term **refugees and migrants** to refer to refugees and all groups of migrants unless one specific subgroup is intended. Refugees and migrants are entitled to the same universal human rights and fundamental freedoms as all people, which must always be respected, protected and fulfilled. However, refugees and migrants are distinct groups governed by separate legal frameworks. Only refugees are entitled to specific international protections, as defined by international refugee law. The entitlement of, and access to, health services for the various groups are determined by national contexts, priorities and legal frameworks.

Asylum seeker. "A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds." *(7)*.

International migrant. Any person who changes his or her country of usual residence *(8)*.

Labour migration. Movement from one country to another, or within a country of residence, for the purpose of employment *(7)*.

Migrant. There is no universally accepted definition of migrant. The International Organization for Migration (IOM) defines a migrant as "[A]ny person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is" *(7)*.

Migrant in an irregular situation (irregular migrant). There is no clear or universally accepted definition of irregular migration but it encompasses "movement that takes place outside the regulatory norms of the sending, transit or receiving countries" *(9)*.

Refugee. "A person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under the mandate of the UNHCR [Office of the United Nations High Commissioner for Refugees], and/or in national legislation" *(10)*. The "applicable refugee" definition used is "a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" *(5)*.

See also UNHCR Master Glossary of Terms https://www.refworld.org/docid/42ce7d444.html.

also the Glossary from the International Organization for Migration (IOM)) *(7)*.

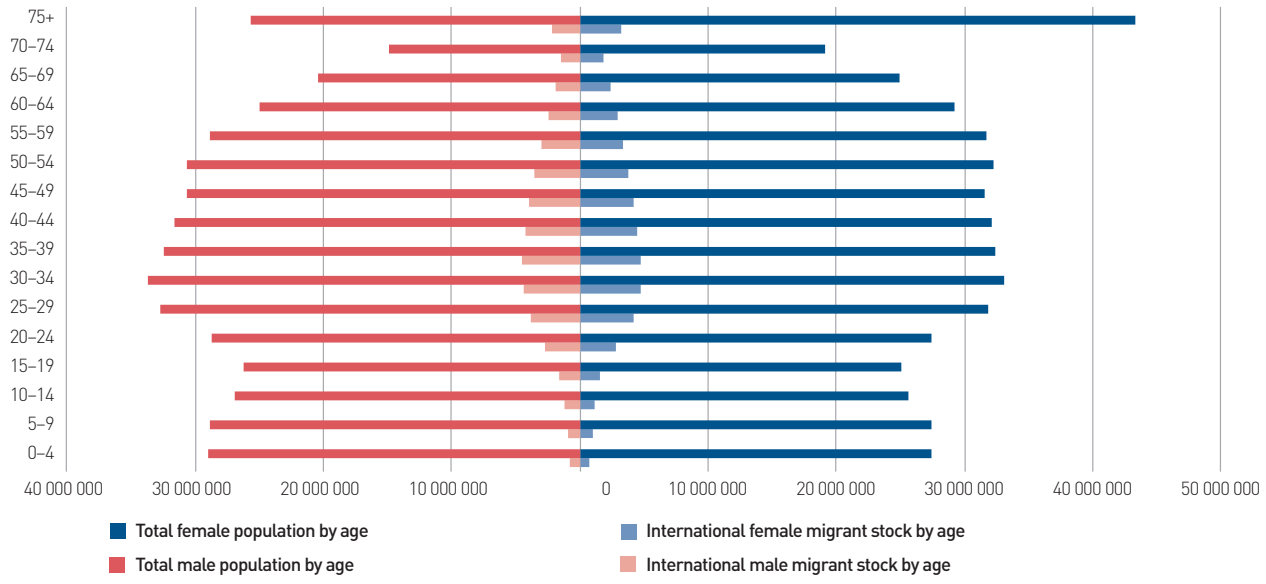
Opportunities and challenges from global displacement and migration

The 2030 Agenda for Sustainable Development *(11)* recognized the positive economic and development contributions made by refugees and migrants. However, refugees and migrants can experience negative health consequences during their displacement and migratory trajectories that can have repercussions on their families, their communities and the host population. This has led to the consideration of displacement and migration as social determinants of health alongside those affecting all of the population *(12)*.

The core tenet of the WHO Commission's Report on Social Determinants of Health published in 2008 was that "the conditions in which people grow, live, work and age have a powerful influence on health, and that avoidable inequalities in these conditions could lead to severe inequalities in health" *(13)*. These are the conditions that lead to unfair and avoidable differences in health status seen within and between countries. In the case of refugees and migrants, unequal access to health prevention and care, and individual experiences influencing their health status take place at every stage of the displacement and migration continuum (origin, transit, destination and return) and individual health status will be subject to factors and influences that are specific to time, place and person. These social determinants of health require a general public health approach. Consideration of the health care issues faced by refugees and migrants also provides an opportunity to detect gaps in routine service delivery and finance arrangements and to strengthen universal health coverage. Such a universal health coverage approach, promoting basic health and well-being for all, is part of the many existing WHO strategies and action plans *(14–16)*.

It is widely recognized that displacement and migration can carry significant benefits and opportunities for refugees, migrants and communities in countries of origin and destination, and refugees and migrants should not be perceived as a burden for social and health services or as people who only have needs. Host countries benefit through the alleviation of labour shortages, importation of skills, contribution to economic growth and participation in the taxation and social welfare schemes. An inflow of labour migrants of working age can compensate for the expected decline of the workforce in societies with reduced birthrates and an ageing population. In 2017, the majority of the international migrants present in the WHO European Region were in the working age group of 25–50 years (Fig. 1.2). The International

Fig. 1.2. Total population and total international migrant stock in the WHO European Region stratified by age and by sex, 2017



Note: data disaggregated by gender were not available for Andorra, Monaco and San Marino.

Source: United Nations Department of Economic and Social Affairs, 2017 *(1)*.

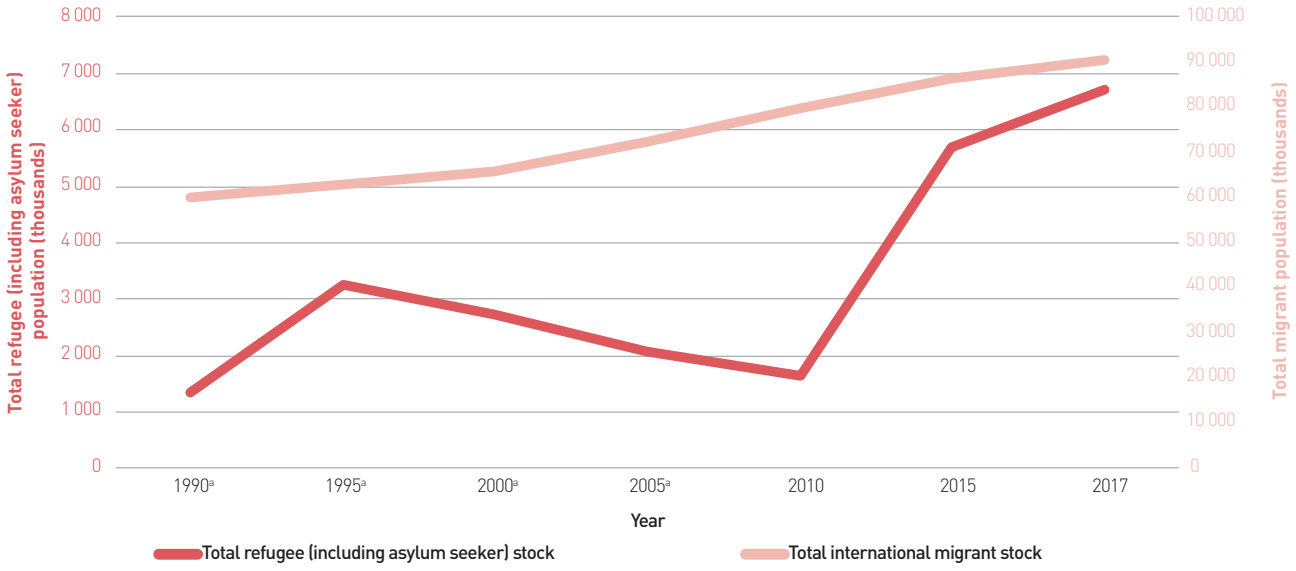
Labour Organization (ILO) has suggested that most current migration is directly or indirectly associated with a search for work opportunities *(17)*, with almost 60 million labour migrants residing in the Region in 2015 (around 12% of all workers) *(2)*. Taking the population as a whole, participation in the workforce is higher for migrants (around 73%) than for the non-migrant population (around 57%) in Europe and central and western Asia.

International migrants represent only 3.3% of the global population but contributed massively to the productivity of the countries that host them, and in several countries international migrants tend to contribute more in terms of tax and other contributions than the benefits they receive *(18)*. Additionally, the global volume of remittances sent back home in 2017 by migrants exceeded US$ 613 billion *(19)*, more than three times the overall official development assistance contributed by member countries of the Organisation for Economic Co-operation and Development in the same year *(20)*. Remittance funds are more often spent in the country of origin on health, livelihood and education for the more than 700 million family members left behind and are, therefore, an important stabilization factor.

Concurrently with a global growth in migration flows for the purpose of employment, there has been a substantial increase in both the number and proportion of refugees and migrants since the late 2000s *(21)*. The proportion of forcibly displaced people has grown from around five in every 1000 of the world's population in 1997 to almost nine in 2017, with a marked increase starting in 2011, in conjunction with unrest and conflicts in west and north Africa and the Middle East, which have particularly influenced more recent migratory dynamics towards the WHO European Region (Fig. 1.3).

The UNHCR estimated that the number of forcibly displaced people globally in 2017 reached 68.5 million, with 25.4 million crossing international boundaries to seek protection *(22)*. In 2017, Turkey continued to be the country hosting the largest number of refugees in the world (3.5 million) *(22)*. In some Member States of the WHO European Region, there are large populations of internally displaced people, who may have specific health and medical needs (e.g. there are over a million in Turkey and Ukraine and a further 208 000 in Georgia). Although this is an important population, this group is not discussed in this report.

Fig. 1.3. Trends in refugee (including asylum seekers) and total migrant population in the WHO European Region, 2000–2017



[a] Data are not available for Montenegro.
Source: United Nations Department of Economic and Social Affairs, 2017 *(1)*.

A growing phenomenon is so-called mixed migration, defined by UNHCR as "situations where a number of people are travelling together, generally in an irregular manner, using the same routes and means of transport, but for different reasons" *(23)*. They might have varying needs and profiles (e.g. refugees, asylum seekers, victims of trafficking, unaccompanied or separated children, potential labour migrants) and might have had the same experiences and/or taken the same migratory route, but the legal status they are deemed to have upon arrival is key in determining their access to health care and protection. Many refugees and migrants end their journey in marginalized urban settings of northern Europe. They are often perceived as competing with poor nationals for wages and social services, and in some societies this can engender xenophobia and anti-migrant sentiments. A very common misperception is that there are too many refugees and migrants, and in some European countries citizens estimate the number of migrants at three or four times more than they really are *(24,25)*. However, refugees and asylum seekers still account for less than one tenth (7.4%) of the international migrant population in the Region.

It was in 2006–2007 that the opportunities and challenges of displacement and migration and the health of refugees and migrants first emerged as key themes in themselves. The High-level Dialogue on Migration and Development in September 2006 and its report to the United Nations General Assembly *(26)* was the first multilateral dialogue on the theme of migration governance, with a focus on ways to maximize the development benefits of migration and to minimize its negative impact by means of multinational cooperation and multisectoral partnership.

Within Europe, one of the principal goals of the Portuguese Presidency of the European Union (EU) was to implement a global approach to migration for the 21st century, including its health implications. This was founded on the understanding that Europe would have continued need for migrants for demographic and economic reasons; that the process of European integration and gradual abolishment of the internal borders between countries of the EU would require a progressive realization of equity in health for all; and that partnerships would be needed not only between EU Member States but also with countries of transit and origin of migratory flows. Two milestone conferences occurred in 2007 which emphasized that health was key to refugee and migrant integration in culturally diverse societies. The Lisbon Conference, Health and Migration in the EU: Better Health for all in an Inclusive Society, hosted by Portugal, emphasized that preventive care and access to care by refugees and migrants were to be understood as a human right; as an essential element of social, economic and political development; and as a prerequisite to realize public health and global health goals *(27)*. The Bratislava Declaration on Health, Human Rights and Migration from the Council of Europe affirmed that well-managed health measures for refugees and migrants, including public health, promote the well-being of all and inclusion and understanding, thus contributing to social cohesion and enhanced development *(28)*. These experiences paved the way towards a number of global and regional initiatives to support migration health.

Measures to support health for all

There are a number of benchmark global and regional health resolutions, strategies and action plans based on the principles and scope of the health for all vision, starting with the Constitution of the World Health Organization of 1948 *(29)*, which stated that "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition", and the International Covenant on Economic, Social and Cultural Rights of 1966, which confirmed the right to "enjoyment of the highest attainable standard of physical and mental health" *(30)*. In 1978, the Alma-Ata Declaration called for the removal of obstacles to health for all individuals, and for the promotion of "well-being, human dignity and enhanced quality of life enabling each person to lead a socially and economically productive existence" *(31)*. The United Nations Millennium Declaration and the Millennium Development Goals of the 2000s maintained that addressing disparities and inequities, particularly for the most vulnerable, was an indispensable foundation of "a more peaceful, prosperous, healthy and just world" *(32)*. In 2009, World Health Assembly resolution WHA62.14 (Reducing Health Inequities through Action on the Social Determinants of Health) outlined measures to tackle

health inequities within and across countries, including by developing and implementing goals and strategies to improve public health, with a focus on health inequities, and integrating health considerations into relevant public policies with enhanced intersectoral action *(33)*. In 2011, the Rio Political Declaration on Social Determinants of Health expressed determination to achieve social and health equity through action on the social determinants of health and well-being by a comprehensive intersectoral approach *(34)*.

The United Nations 2030 Agenda for Sustainable Development, adopted in 2015 by Member States of the United Nations, elaborated a transformative and inclusive strategy and set goals and recommended actions for all countries to end poverty and address economic, social and health goals while leaving no one behind *(11)*. The 2030 Agenda defined 17 Sustainable Development Goals (SDGs) and numerous specific targets to mobilize national and international efforts and support monitoring and evaluation of the 2030 Agenda's progress. It presented an integrated approach based on increasing the empowerment of the disadvantaged and marginalized to support sustainable economic growth, employment and good health. Remedying the gap that existed in the Millennium Declaration and the Millennium Development Goals, migration featured prominently in the 2030 Agenda, which broke new ground in recognizing the "positive contribution of migrants for inclusive growth" and the "multi-dimension reality" of migration. SDGs of direct relevance for refugee and migrant health *(35,36)* are the core health-related SDG 3 (good health and well-being; specifically targets 3.1–3.5, 3.8, 3.c and 3.d), SDG 10 (reduce inequalities, specifically target 10.7) and SDG 17 (partnerships for sustainable development) *(37)*.

The Tokyo Declaration in 2017 put forward a vision of universal health coverage: "all people obtain quality health services when they need them, without falling into poverty to pay for them" *(16)*. This needs services that are cost-effective and affordable, and the Declaration identified three related strands: access, quality and financial risk protection *(16,38)*. Exclusion and marginalization hinder timely case detection and management and can represent a major public health risk. WHO in 2015 estimated that at least 400 million people lacked access to essential health care, with many refugees and migrants included in that group *(39)*. The WHO Framework on Integrated People-centred Health Services *(14)* envisaged the engagement and empowerment of people and communities; the strengthening of governance and accountability; the reorientation of health systems around the comprehensive needs of people rather than individual diseases; and a future in which all people have equal access to quality health services that meet their life-course needs and respect their preferences. The Framework considered that refugee and migrant health should be mainstream within the public health scope of population-based health strategies.

Measures to promote the health of refugees and migrants

Access to equitable health prevention and care for all, including refugees and other migrants, is explicitly or implicitly defined in numerous international legal and policy human rights instruments *(40)*:

- the International Convention on the Elimination of All Forms of Racial Discrimination of 1963 (Art. 5. e, iv) *(41)*;
- the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families of 1990 (Arts. 28,43,45), ratified by five of the 53 Member States *(42)*;
- the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children of 2000, ratified by 52 of the 53 Member States of the WHO European Region *(43)*;
- the Protocol against the Smuggling of Migrants by Land, Sea and Air of 2000, ratified by 48 of the 53 Member States *(44)*; and
- the United Nations Convention Related to the Status of Refugees, adopted in 1951, and the revised Protocol Related to the Status of Refugees, adopted in 1967 *(5)*.

The United Nations High-level Dialogues on Migration and Development (2006 and 2013) expressed the collective commitment to tackle migration's challenges through dialogue and cooperation, rather

than antagonism and isolation *(26,45)*. The New York Declaration for Refugees and Migrants *(46)* outlined a global compact for safe, orderly and regular migration and a global compact on refugees *(47)*. It committed Member States to:

- protect the safety, dignity, rights of all migrants regardless of migratory status;
- support countries rescuing, receiving and hosting large numbers of refugees and migrants;
- integrate migrants needs and capacities and those of receiving communities into humanitarian and development planning;
- combat xenophobia, racism and discrimination;
- develop state-led processes, non-binding principles and voluntary guidelines on the treatment of vulnerable refugees and migrants; and
- strengthen global governance of migration and partnership through the development of a global compact for safe, orderly and regular migration and a compact for refugees by the end of 2018.

A global commitment of Member States of the World Health Assembly to improve the health of migrants led to resolution WHA61.17 in 2008 *(48)*. It called upon Member States to promote migrant-sensitive health policies and to promote equitable access to health promotion, disease prevention and care for migrants, without discrimination on the basis of gender, age, religion, nationality or race. The resolution highlighted that migrants' fundamental health needs were not always adequately met, thus raising concerns for:

- the negative health implications this could have for vulnerable migrants and communities;
- the possible jeopardy in the realization of country and global health goals; and
- negative implications for equity, social cohesiveness and inclusiveness in countries increasingly experiencing population movements, either forced or voluntary.

It identified four key public health goals that link issues of human rights, public health, humanitarian aid and development:

- ensuring a migrant's right to health;
- reducing disparities in health status and access to care;
- reducing excess mortality and morbidity through life-saving interventions; and
- minimizing the negative impact of the migration process.

The goals of resolution WHA61.17 were emphasized by the report from the WHO Commission on Social Determinants of Health *(13)*, which concluded that socioeconomic, cultural, environmental and lifestyle factors are key determinants of health and that health status is generally worse in lower socioeconomic positions. These determinants are equally true for refugees and migrants as for the general population and are also largely responsible for the inequalities and inequities within and between different countries and population groups in terms of health. The Tallinn Charter *(49)* in the WHO European Region also recognized that the process of migration was itself a social determinant of health that required multisectoral consideration. Unfortunately, the global financial crisis in 2008 resulted in setbacks in access to health for refugees and migrants in some regions. This was linked to austerity measures and growing anti-migrant sentiments fuelled by the economic situation *(50)*, a trend still felt a decade later.

World Health Assembly resolution WHA70.15, Promoting the Health of Refugees and Migrants, in 2017 called upon Member States to develop frameworks of priorities and guiding principles at global, regional and country levels to support the global compact on refugees and the global compact for safe, orderly and regular migration; identify and collect evidence-informed data on best practices and lessons learned; and strengthen international cooperation on the health of refugees and migrants *(51)*. In 2017, a framework of priorities and guiding principles to promote the health of refugees and migrants was developed to inform discussions and provide a resource for Member States and partners engaged in the development of these global compacts to ensure that health aspects were adequately addressed and to serve as a foundation for the development of a draft global plan of action on the health of refugees and migrants *(52)*.

Two global consultations on migrant health also took place. In 2010, Health of Migrants: the Way Forward *(53)* created an action framework designed to assist in moving forward resolution WHA61.17 *(48)*, identifying four key action domains:

- **monitoring migrant health** with the collection of standardized and comparable data and mapping of good practices;

- **adopting international policy and legal frameworks** to ensure national health policies that promote equal access to health services and social security for all migrants;
- **creating migrant-sensitive health systems** that are financially sustainable, culturally sensitive and linguistically appropriate and delivered by a professional workforce aware of health issues associated with migration; and
- **establishing multisectoral partnerships and frameworks** for dialogues and cooperation across sectors and regions for global and regional consultative processes.

In 2017, the second consultation examined the experience of countries and health actors that had implemented the framework from the first consultation and reanalysed it in light of the 2030 Agenda, the SDGs and the United Nations global compacts on refugees and migrants (the Colombo Statement) *(54)*.

Strategies for refugee and migrant health in the WHO European Region

Within the WHO European Region, additional international instruments and agreements defined and authenticated the basic rights and of refugees and migrants and their access to health care and services. In some countries, these principles are also reflected in national legislation, where the right to health is noted at constitutional level. In countries where the constitution does not specifically provide for these rights, numerous other protocols, agreements and corresponding policies have been promulgated that support the health of refugees and migrants.

The EU considered the rights of non-EU citizens in a number of measures: the Tampere European Council meeting of 2002 *(55)*, the 2000 Charter of Fundamental Rights of the European Union *(56)*, and the Council of Europe's standards for the reception of applicants for international protection *(57)* and its resolution 1509 on human rights of irregular migrants *(58)*.

The Common European Asylum System was established in the EU to harmonize the protection mechanism in its Member States, improve cooperation among the Member States and increase solidarity and a sense of responsibility among EU and non-EU countries. The directives and regulations that are part of the Common European Asylum System set minimum standards for various procedures, including health care and rights, during the asylum-seeking process *(59)*.

In 2015, the WHO Regional Office for Europe organized a High-level Meeting on Refugee and Migrant Health *(60)* to address salient aspects of meeting the short- and long-term health needs of refugees and migrants and to respond to the public health challenges associated with their rapid arrival. Its conclusions were published in the outcome document Stepping up Action on Refugee and Migrant Health: Towards a WHO European Framework for Collaborative Action *(60)*. It recommended creation of a common framework supporting coordinated and collaborative action across the WHO European Region.

Consultation, negotiation and collaborative action in the follow-up to the High-level Meeting produced a common regional response and a regional resolution *(61)*. The Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region was unanimously endorsed by the Regional Committee for Europe in September 2016 *(62)*.

The Strategy and Action Plan outlined nine strategic areas and five indicators to support development and monitoring of national health policies and refugee and migrant health-related priority areas (see Chapter 3). It also catalysed and contributed to relaunching the refugee and migrant health agenda globally, with WHA70.15 *(51)* and the Second Global Consultation on Migrant Health *(54)*. Chapter 3 outlines the results of the first survey to monitor these indicators in the Region.

Public health aspects of refugee and migrant health

Until the last few decades of the 20th century, refugee and migrant health policies, where they existed, tended to have an almost exclusively national focus, with concentration on avoidance of importation of diseases from abroad. However, studies have suggested that refugees and migrants at the early stages of displacement and migration were often healthier than host populations (often referred to as the healthy migrant effect) *(63–65)*. Over time, however, disparities, inequalities and health risks inherent to the status of migrants and the migration process can emerge. Refugees and migrant categories such as and irregular migrants in particular are more vulnerable and susceptible to the subsequent acquisition of many communicable diseases, including vaccine-preventable diseases and antimicrobial resistance (AMR) *(66,67)*. This reflects issues such as poor health services and vaccination coverage in their country of origin, exposure to overcrowding and poor sanitation facilities in transit or at reception, and the likelihood of living in poor conditions with difficulty in accessing health care initially in the destination country *(68)*.

Similarly, displacement and migration itself itself can also increase vulnerabilities to NCDs through interruptions in management or loss of medication or equipment during travel or through legal status issues for migrants, which often restrict access to and utilization of the necessary care. Changes in lifestyle and adoption of unhealthy behaviours, such as sedentary lifestyles and poor diet, can also contribute *(69)*. Mental health conditions are particularly sensitive to any uncertainty over legal status, residency, work permits and the broader social perspectives in the host country *(70)*. Labour migrants may be proportionally more common in less-safeguarded employments, where they may be at risk of occupational death and injuries and chronic work-related illnesses or psychosocial stressors linked to unhealthy living and working conditions *(71)*.

These issues have determined a paradigm shift in the migration and health discourse from a focus on national border and health security to issues of population-based equity, preventive care, right to health, social determinants of health and universal health coverage.

Across the WHO European Region, there are fundamental differences in the way health services are organized, financed and governed for the population as a whole, with health policies for refugees and migrants adding a further layer of complexity. The EU has policies and common understandings directed towards a coordinated approach to the successful integration of third-country nationals (nationals of non-EU countries). These policies recognize that third-country nationals have less favourable outcomes in terms of employment, education and social inclusion, indicators which are often associated with downstream health outcomes *(72,73)*. Nevertheless, differences exist between countries in access requirements to health services *(74)* and the level of implementation of regionally agreed strategies, recommendations and policies. This is particularly the case for irregular migrants *(75,76)*. Short-term cost-savings linked to limiting refugees' and migrants' access to preventive care, early diagnosis and care for both communicable diseases and NCDs are often soon lost through the costs of provision of emergency care and treatment for late presentation for care *(77)*. In general, regional health policies recommend or define that emergency and urgent care should be available to all refugees and migrants throughout the Region regardless of status.

Refugees and various categories of migrant might face challenges in all of the 5As of access to health care: availability, adequacy, accessibility, affordability and appropriateness *(78)*. These health system inputs are key to population health outcomes and to the achievement of global health goals. Failure in ensuring that refugees and migrants have access to equitable health care deprives refugees, migrants and host population of the positive effects of population movement and can have negative public health repercussions for all population groups. Lack of disease prevention, delayed access to diagnosis and care, substandard quality and interrupted treatment, lack of adequate surveillance and case management, and lack of targeted information and health education are all avoidable situations experienced by refugees and migrants that can have important public health costs and repercussions in the context of both communicable diseases and NCDs. This is of particular public health relevance where refugees and migrants may

represent a sizeable proportion of the community *(79)*. Chapter 2 discusses this in more detail but several key public health arguments for the promotion of refugee and migrant health can be made. Foremost of these is the achievement of the goal of universal health coverage, as discussed above.

The right to health is a basic human right. The right to access preventive, curative and palliative health care, but also the right to the underlying social preconditions for health, is a basic human right under the 1966 International Covenant on Economic, Social and Cultural Rights *(30)*. In 2009, the Committee on Economic, Social and Cultural Rights in General Comment 20.30 stated, "Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation" *(80)*.

Healthy refugees and migrants contribute actively to the host society and country of origin. Although refugees and migrants represent less than 5% in population terms, they contribute massively to the productivity of the countries that host them. In several countries, they tend to contribute more in terms of tax and contributions than the benefits they receive *(18)*. Additionally, remittances sent back home are often spent on health, livelihood and education for the family members left behind and are, therefore, an important stabilization factor *(19)*.

Early diagnosis and treatment save lives and cut treatment costs. Primary care is ideally the first point of access to health services but often refugees and migrants access health services in emergencies only. Ideally, health care should be provided as part of routine services, starting in reception centres and moving on to the final destination. Treating a condition when it becomes an emergency not only endangers the health of the patient but can also result in a greater economic burden to the health care system. A study carried out in three European countries indicated cost-savings of around 9% could be achieved if all migrants in an irregular situation made regular use of preventive health care compared with the costs associated with no access to health care *(77,81)*. A 2015 study analysed economic costs related to the exclusion of irregular migrants from access to the mainstream health care system. The results indicated that timely treatment in a primary health care setting was always cost-saving compared with treatment in a hospital setting (for direct medical, nonmedical and indirect costs). This holds true from the perspective of all three stakeholders: the patient, the third-party payer (health care system) and society as a whole *(82)*.

Prioritizing vulnerable populations and most at-risk individuals in societies is a sound public health strategy. Inclusiveness rather than exclusion is a key strategy for the achievement of global health goals and cost-effective public health systems. The displacement and migratory trajectories often places individuals at increased risk for certain diseases. For example, the Joint United Nations Programme on HIV and AIDS recognizes that displacement and migration can place people in situations of heighten vulnerability to HIV *(83)*. In 2015, more than one third of all newly diagnosed HIV cases in the EU/European Economic Area (EEA) were of foreign origin; in 10 EU/EEA countries, more than half of all newly diagnosed HIV cases were of foreign origin *(84)*. Improved monitoring, better understanding of risk factors, strengthened prevention and testing programmes for refugees and migrants, removal of barriers to the provision and updating of services, and a strengthened evidence base are all necessary public health interventions.

Clusters of the population with lower health coverage can have negative health outcomes for the whole community. Effective immunization rates in a population prevent the resurgence of vaccine-preventable diseases. Decline of immunization rates in countries of origin and barriers to accessing services or completing vaccination schedules owing to mobility are common causes of the lower vaccination coverage observed among refugees and migrants in Europe *(76,85)*. In addition, information on the immunization status of refugees and migrants is often lacking because they may not be specifically targeted in surveillance programmes *(85)*. Delays in the adoption of customized preventive health programmes, compounded by the late recourse refugees and migrants have to health care, can cause the resurgence of vaccine-preventable diseases and other outbreaks in communities. For example, TB is primarily a disease of poverty, with social deprivation and substandard living conditions magnifying the risk of infection *(86)*. Evidence from EU countries in 2017 revealed that 40.2% of non-EU-born individuals were at risk of poverty and social exclusion versus 21.7% of native-born individuals, which may shed some light on why refugees

and migrants experience an unequal burden of TB in many countries in the WHO European Region *(87)*. In Europe, multidrug-resistant TB (MDR-TB) is more prevalent among refugees and migrants than in host populations, again linked to failures within health systems in terms of detection of latent TB, late initiation of treatment and incomplete treatment courses *(66)*.

Refugee and migrant health security is part of global health security. Large-scale cross-border movement and far-reaching webs of travel and trade that connect communities, plus restricted access to health care for refugees and migrants, have the potential to allow the emergence and re-emergence of infectious disease threats *(88,89)* and the rise and spread of AMR *(67)*. Collective health security is ultimately the sum of individual health security, which is best achieved through universal health coverage. The Review Committee of the International Health Regulations has recommended that WHO should work with states party to the Regulations to ensure that their core capabilities and contingency plans include arrangements for refugees and migrants *(90)*.

Population diversity changes epidemiological profiles. Some population movement associated health determinants and influences extend into the next generation and beyond, affecting the descendants of refugees and migrants and gradually the epidemiological profile of a country (e.g. the haemoglobinopathies *(91,92)*). This has impact for genetically related illnesses and individualized disease treatments, including the availability of suitable donors for transplantation *(93)*. Refugee and migrant communities and their descendants frequently have different personal travel patterns to other non-migrant travellers (e.g. visiting friends and relatives), which may expose them to different travel-related health risks *(94)*.

Achieving the SDGs and leaving no one behind. Displacement and migration are some of the defining features of the 21st century and can contribute to achieving the SDGs. In order for this to happen, a better understanding is needed of the relationships between displacement, migration and key development issues such as health, education, gender, labour and urbanization.

Conclusions

Basic health and well-being for all is a key part of many WHO strategies, action plans and frameworks, both globally and regionally. This report is intended to create an evidence base to aid Member States of the WHO European Region and beyond in promoting refugee and migrant health by implementing the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region and other frameworks and resolutions. The report focuses on the public health aspects of public health aspects of population displacement and international migration in the WHO European Region, although many of the same issues will be faced within a country by those migrating internally and by vulnerable groups. Refugees and migrants may face specific determinants of health in their country/place of origin, during transit and at their final destination, such as perilous journeys, detention, violence and exploitation, new lifestyles linked to acculturation, unsafe or unhealthy living and working conditions, and limited or conditional access to health care. They may also face certain challenges to accessing health care, including financial, administrative, language and cultural barriers, as well as lacking an understanding of how health care is organized and delivered. Consequently, national health systems of the transit and final destination countries need long-term policies and health system structural adaptations to address the challenges that refugees and migrants face. Acknowledging the heterogeneity inherent in persons who are displaced or migrating is important for the realization of targeted refugee and migrant health programmes and policies that will ensure health and well-being for all.

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Annex 1.1. Population and international migrant stock in the 53 Member States of the WHO European Region

Member State	Total international migrant population	Total national population	International migrants (% total population)
Albania	52 484	2 930 187	1.8
Andorra	41 039	76 965	53.3
Armenia	190 719	2 930 450	6.5
Austria	1 660 283	8 735 453	19.0
Azerbaijan	259 241	9 827 589	2.6
Belarus	1 078 652	9 468 338	11.4
Belgium	1 268 411	11 429 336	11.1
Bosnia and Herzegovina	37 100	3 507 017	1.1
Bulgaria	153 803	7 084 571	2.2
Croatia	560 483	4 189 353	13.4
Cyprus	188 973	1 179 551	16.0
Czechia	433 290	10 618 303	4.1
Denmark	656 789	5 733 551	11.5
Estonia	192 962	1 309 632	14.7
Finland	343 582	5 523 231	6.2
France	7 902 783	64 979 548	12.2
Georgia	78 218	3 912 061	2.0
Germany	12 165 083	82 114 224	14.8
Greece	1 220 395	11 159 773	11.0
Hungary	503 787	9 721 559	5.2
Iceland	41 853	335 025	12.5
Ireland	806 549	4 761 657	16.9
Israel	1 962 123	8 321 570	23.6
Italy	5 907 461	59 359 900	10.0
Kazakhstan	3 635 168	18 204 499	20.0
Kyrgyzstan	200 294	6 045 117	3.3
Latvia	256 889	1 949 670	13.2
Lithuania	124 706	2 890 297	4.3
Luxembourg	264 073	583 455	45.3
Malta	45 539	430 835	10.6
Monaco	21 255	38 695	54.9

Member State	Total international migrant population	Total national population	International migrants (% total population)
Montenegro	70 984	628 960	11.3
Netherlands	2 056 520	17 035 938	12.1
Norway	798 944	5 305 383	15.1
Poland	640 937	38 170 712	1.7
Portugal	880 188	10 329 506	8.5
Republic of Moldova	140 045	4 051 212	3.5
Romania	370 753	19 679 306	1.9
Russian Federation	11 651 509	143 989 754	8.1
San Marino	5 243	33 400	15.7
Serbia	801 903	8 790 574	9.1
Slovakia	184 642	5 447 662	3.4
Slovenia	244 790	2 079 976	11.8
Spain	5 947 106	46 354 321	12.8
Sweden	1 747 710	9 910 701	17.6
Switzerland	2 506 394	8 476 005	29.6
Tajikistan	273 259	8 921 343	3.1
The former Yugoslav Republic of Macedonia	130 972	2 083 160	6.3
Turkey	4 881 966	80 745 020	6.1
Turkmenistan	195 061	5 758 075	3.4
Ukraine	4 964 293	44 222 947	11.2
United Kingdom	8 841 717	66 181 585	13.4
Uzbekistan	1 159 190	31 910 641	3.6
Total	**90 748 113**	**919 457 593**	**9.9**

Source: United Nations Department of Economic and Social Affairs, 2017 *(1)*.

CHAPTER 2

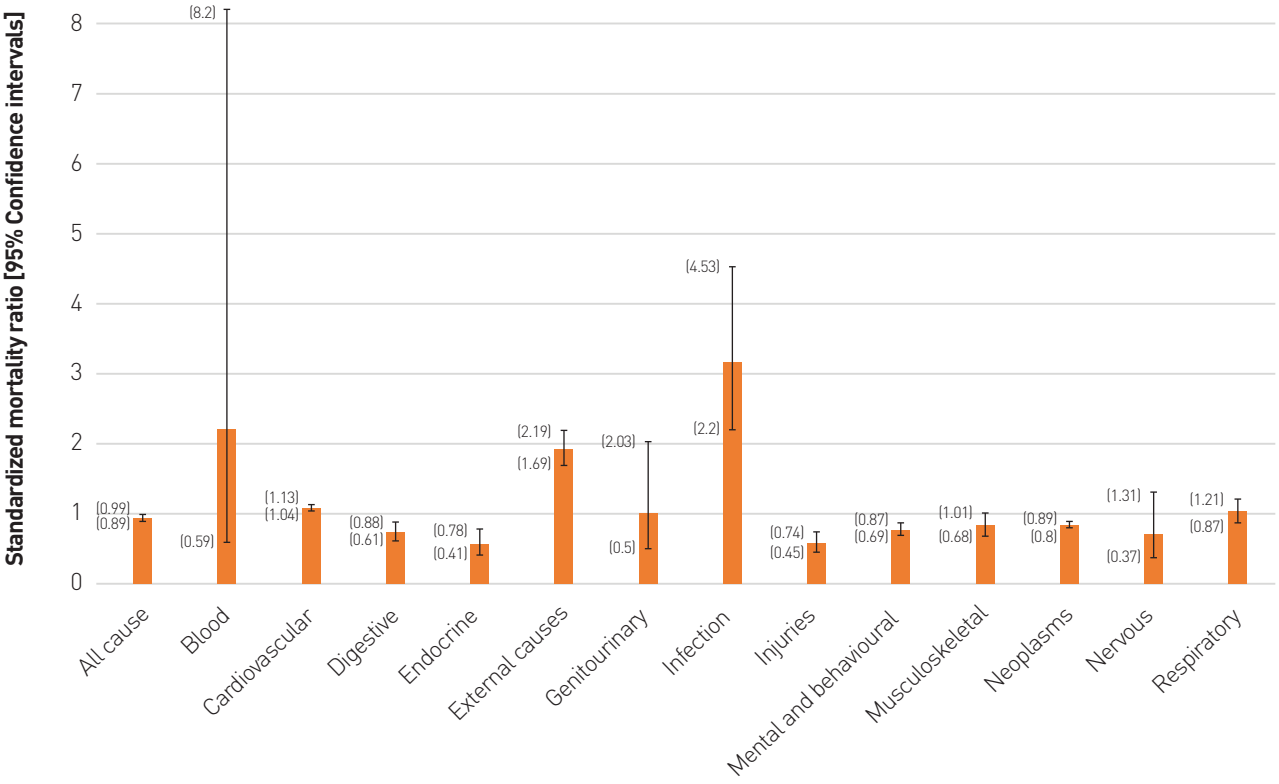
Evidence on the health of refugees and migrants in the WHO European Region

Introduction

This chapter presents the available information on the current health status of refugees and migrants and how health services are organized in the WHO European Region. The health status of migrants and refugees can be assessed in relation to either that of the host population in the country of destination or that of the population in the country of origin *(1)*. The former is most commonly used in the WHO European Region and that is the comparison used here.

Refugees and migrants may bring health risks to their country of destination (e.g. lack of immunization) and they may be exposed to new risk factors in transit or at their destination *(2)*. The displacement and migratory experience can alter the pattern of morbidity and mortality for specific diseases, making these either better or worse than in the country of origin. As refugees and migrants spend longer in the country of destination, their health status may converge with that of the host population *(1)*. Based on figures available in published literature, standardized mortality ratio estimates tend to be lower in refugees and migrants than in the European host population for all-cause mortality, neoplasms, mental and behavioural conditions, injuries, endocrine disorders and digestive conditions, but higher for infections, external causes, diseases of the blood and blood-forming organs and cardiovascular diseases (Fig. 2.1).

Fig. 2.1. Summary standardized mortality ratios for refugees and migrants compared with the host population in the WHO European Region for various mortality causes



Notes: Mortality causes are based on the all-cause mortality and International Classification of Diseases 10th Revision; values below 1.0 indicate a mortality advantage for refugees and migrants; standardized mortality ratios were calculated from mortality rates in available in published scientific literature (940 cause-specific estimates) as a subgroup analysis of a global meta-analysis.

Source: Aldridge et al., 2018 *(3)*.

Most literature regarding refugee and migrant health in the WHO European Region has addressed communicable diseases, with less information on the risk for NCDs, such as cardiovascular diseases, stroke and cancer; risks for these NCDs can increase with duration of stay in the host country *(4,5)*. Factors such as country of origin, specific health outcome considered, and duration and socioeconomic conditions of stay have a major impact on refugee and migrant health and so studies can have differing or contesting observations *(6–9)*.

Refugee and migrant health is highly complex, with risks and exposures associated with the displacement and the migratory process, respectively, and the social determinants of health in the host country. Consequently, it is often difficult to generalize research findings to wider refugee and migrant populations in a country, in a region or globally, and this should be kept in mind when considering information on the health status of refugees and migrants in the WHO European Region *(10)*.

The legal status of different migrant groups (e.g. labour migrants or irregular migrants) and reason for displacement or migration also have an impact on health. Research from Finland indicated that forced displacement may be related to an increase in risk of death from cardiovascular diseases *(11)*. Irregular migrants in the WHO European Region have been shown to be at greater risk of poor mental health than migrants with documentation or the host populations *(12)*. Refugees and asylum seekers may have elevated rates of perinatal mortality and prevalence of PTSD *(13,14)*.

Gender is an additional important aspect to consider when analysing refugee and migrant health but data are rarely disaggregated by sex and there is no systematic, comparable information on those who do not fit the typical binary male and female categories. This report highlights the gender aspects wherever data are available.

When studying the health status of refugees and migrants, it is also important to recognize that outcomes are often a result of an entire lifetime of risks and exposures, which may have occurred before, during or after the displacement or migratory process. For example, children belonging to different migrant groups often have greater health differences than those between migrant children in general and non-migrant children in European countries, and elderly migrants who have aged within the destination country may face different issues to those who migrate in older age. It is important have a life-course approach to refugee and migrant health, similar to the general population. However, such an approach is limited by lack of data, especially on elderly migrants *(15–17)*.

Tailored health care can only be provided if the needs of a population group are understood. However, in general, there is a lack of comprehensive, routinely collected and comparable data focusing on refugee and migrant health in the WHO European Region, which limits the ability to draw generalized conclusions within this report. This is particularly true for certain vulnerable groups such as irregular migrants. One of the main findings and challenges of developing the report was the use of different terminologies to refer to refugees and migrants. Documents reviewed used different terms such as foreign born, foreign origin and immigrants to refer to refugees and migrants, making it impossible to differentiate outcomes among groups. If the target group for a study was clearly mentioned in the source article, it is reflected in the report. In other instances, as indicated in Chapter 1, the term refugees and migrant is used. Other issues that hamper analysis include differences in national surveillance systems; data confidentiality issues and gaps in existing data; methodology issues such as the geographical area studied and the size of the study population; and the lack of reliability in calculations of disease prevalence or incidence rates among refugee and migrant populations. Best efforts have been made to identify and utilize in this report as much of the available information as possible to generate an overview of refugee and migrant health in the WHO European Region. The chapter begins with a description of the health profile of this population and then examines health care organization and delivery in the WHO European Region. Identified gaps in coverage and discrepancies are discussed plus the specific issues of achieving culturally sensitive health systems.

Methodology

Data for this report were obtained from a scoping review of recent literature (more than 13 000 documents, mainly since 2014) published in English and Russian and identified in the Cochrane Library, Embase, PubMed and Web of Science databases. Systematic literature reviews, grey literature and primary studies were also reviewed as were documents and data provided by some Member States and collaborators. Additional desk reviews were conducted when necessary.

Health profile

Communicable diseases

Key points: communicable diseases

- Refugees and migrants can be more vulnerable to infectious diseases in places or origin, transit and destination because of exposure to infections, lack of access to health care, interrupted care and poor living conditions.
- There are indications that there is a very low risk of transmitting communicable diseases from the refugee and migrant population to the host population in the WHO European Region.
- Refugees and migrants in the Region may have lower uptake of recently introduced vaccinations, such as for human papillomavirus or influenza.
- Refugees and migrants arriving from countries with high prevalence of TB are at greater risk of infection, depending on the conditions experienced in their country of origin, during their travel and their living and working conditions in the host country. Latent TB can be a particular problem as it can go undetected.
- A significant proportion of those refugees and migrants living with HIV in the Region acquire infection after they have arrived in their new country. Refugees and migrants are more likely to be diagnosed later in their HIV infection.
- Infections with hepatitis B and C viruses are more common in refugees and migrants from countries where the virus is endemic but prevalence of these infections among refugee and migrant populations vary across Member States of the Region.
- Tropical and parasitic infections that are not seen in Europe normally may enter the Region with migration from areas where the infections are endemic but are also a risk for travellers to these areas and for refugees and migrants and their descendants revisiting the country of origin.

Although there is perhaps more information available in terms of migration and health with regard to communicable diseases than for other conditions or illnesses *(18)*, there are fewer studies on surveillance systems, which limit an understanding of the total impact of migration on European infectious disease epidemiology. Aggregated data do indicate that increased transmission of communicable diseases is often seen among refugees and migrants, but transmission from the refugee and migrant population to the host population is considered to be low and mostly related to poor living conditions and vaccination coverage gaps in the host population *(19–22)*. In terms of acute or newly acquired infections, refugees and migrants are generally at the same risk for respiratory and gastrointestinal diseases as other residents and travellers. However, circumstances encountered before, during and after displacement and migration can influence outcomes. Breakdown in health systems in the country of origin can lead to lack of immunization *(23)*, particularly in children, and poor living conditions in transit or at the destination country can create risks for acquiring infections, including vaccine-preventable

diseases *(19,24)*. Living with poor sanitation and contaminated water before or during the migratory journey increases the risk for a variety of infections: bacterial, viral and parasitic *(25)*. Common skin and eye infections (scabies and conjunctivitis) and upper respiratory tract infections are often identified in refugees and migrants rescued at sea *(26–28)*.

Mortality rates for infectious diseases were generally higher among migrants in five Member States of the WHO European Region (Denmark, France, the Netherlands, Spain and the United Kingdom (England, Scotland and Wales)) and among those from east Asia, eastern Europe and Turkey *(29)*. The two main causes of deaths were TB and HIV/AIDS *(29)*. The proportion of HIV and TB cases attributed to the refugee and migrant population varies geographically across the Region, with those Member States with low endemic levels (mostly western Member States) showing a higher proportion of cases within the refugee and migrant population *(30,31)*.

Detection and surveillance systems for imported infections are routine components of national health systems in the Region and are integrated into activities that support the International Health Regulations *(21,32)*. However, infections in those migrating have minimal public health implications for most host populations in the WHO European Region. The unprecedented arrival of large numbers of refugees and migrants into the EU/EEA since 2010 has not been associated with significant infectious diseases outbreaks *(21,33)*. Population mobility between and across areas of varying incidence and prevalence for many important infections may have epidemiological consequences for the public health systems of countries.

The course of infectious diseases also varies, with some being latent or chronic. This may explain observations indicating that, in general, refugee and migrant populations in the Region can be disproportionately affected by TB, hepatitis B virus (HBV) infection, HIV infection and some tropical or parasitic infections (e.g. malaria and Chagas disease) *(19,25,26,34)*.

Vaccine-preventable diseases

For a variety of reasons, refugees and migrants may arrive in Europe with incomplete or interrupted immunization schedules *(24)*, thus leaving them vulnerable to vaccine-preventable diseases in transit *(35,36)* and destination countries and potentially creating a public health challenge for underimmunized or unvaccinated populations in the host countries. Factors such as language, cultural and economic barriers, and uncertain legal status can influence the vulnerability of refugees and migrants to vaccine-preventable diseases.

Recent WHO estimates suggest that global childhood primary immunization rates are around 86% and that nearly 20 million infants have missed basic vaccinations *(37)*. Children make up 25% of refugees and migrants, and they are the group at greatest risk of vaccine-preventable diseases as they may not have received all recommended vaccinations *(36)*. For example, children who migrated to Germany were three times more likely to be unvaccinated against measles than host children *(38)*; this lower coverage was also seen in Italy and Spain *(38)*. In 2010–2013, nearly 80% of newly arrived refugee and migrant children in Greece had an undetermined vaccination status, yet assessment of secondary indicators of vaccination suggested prior basic immunization in 58% of the children *(39)*.

Data regarding vaccine use in older populations in the WHO European Region showed variation between Member States *(40)*. There was an overall lower uptake in older migrants living in Israel, Italy and Spain *(40)*, particularly for seasonal influenza vaccines (43% lower uptake in Israel and Spain, 25% lower in Italy) and pneumococcal vaccine (33% lower uptake in Israel and Spain) *(40,41)*. By comparison, migrant status had no effect on influenza vaccination status in older migrants or those at greater risk of influenza in Germany *(42)*.

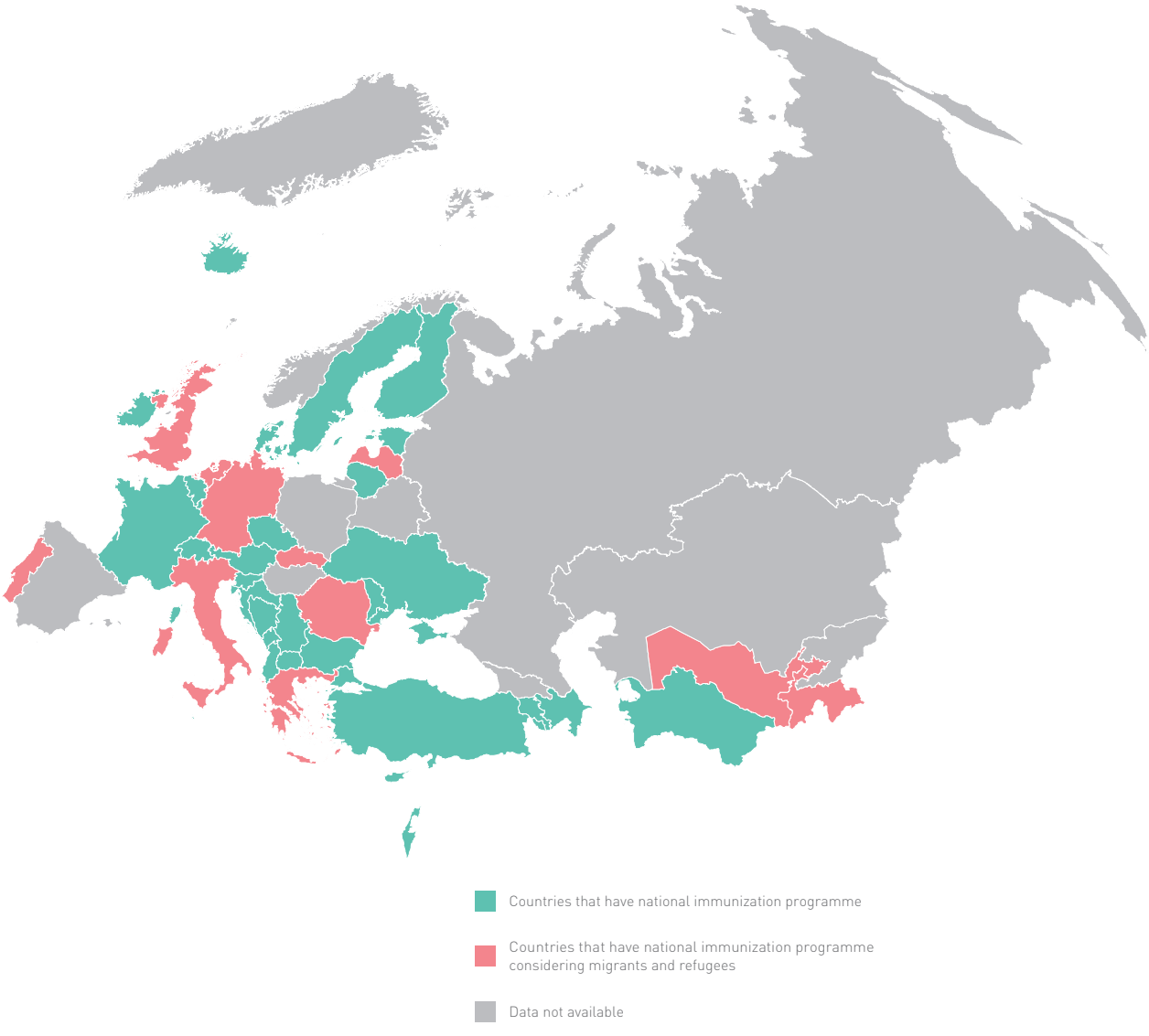
Diphtheria is a vaccine-preventable disease of potential concern as the majority of refugees and migrants arriving in Europe have come from countries where the disease is endemic and are likely to have been exposed to risk factors such as overcrowding and poor hygiene during transit or upon arrival *(43)*. In 2009–2014, 142 cases of diphtheria (25 with cutaneous diphtheria) were reported among recently arrived refugees and asylum seekers in 12 countries (Austria, Belgium, Finland, France, Germany, Latvia, Lithuania, the Netherlands, Norway, Spain, Sweden and the United Kingdom) *(43)*. The countries of probable origin were Afghanistan, Angola, Cambodia, Cameroon, the Democratic Republic of the Congo, Ethiopia, Gambia, India, Kenya, Madagascar, Mozambique, Pakistan, the Philippines, Sierra Leone, Sri Lanka, Thailand and Togo.

Similar to influenza vaccinations, migrant populations have been observed to have lower vaccination rates against human papillomavirus *(44)*.

In general, data indicate that duration of residence in the host country is associated with increased vaccination uptake in migrant populations; for example, in Italy rubella vaccination uptake in women of childbearing age was 30% in those with residency of fewer than five years but 43% in those resident for more than 10 years *(45)*. These differences have been attributed to factors such as integration and improved linguistic capacity over time.

The diverse nature of refugee and migrant populations coupled with differences in the duration, direction and conditions of their travel to the WHO European Region make it difficult to draw general conclusions about vaccination status and unmet needs. Given the safety of most modern immunizing agents, the immediate response to new arrivals is to ensure provision of the basic vaccines based on the immunization schedule of the country of their residence. In Member States with large resident refugee and migrant populations, modified national immunization schedules for those with interrupted or undocumented vaccination histories can provide general guidance to health care providers *(46)*. A 2017 WHO review found that only some Member States in the Region had a national immunization programme that considered refugees and migrants in the programme (Fig. 2.2) *(36)*. Immunization programmes are discussed further under Preventive care.

Fig. 2.2. Member States of the WHO European Region with a national immunization programme that includes refugees and migrants



Source: De Vito et al., 2017 *(36)*.

Tuberculosis

TB presents a set of ambiguous symptoms and diagnosis is not always straightforward. Globally, about one third of the world's population has latent TB, and those with latent TB have a 5–15% lifetime risk of progression to active disease *(47)*.

In the WHO European Region, there are marked differences in TB incidence and prevalence rates within Member States, with over 80% of TB cases in the Region occurring in 18 Member States (Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Romania, the Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan) *(48)*. Foreign-born individuals make up about 8% of all TB notifications in the Region, but the proportion varies geographically (Fig. 2.3a). Large disparities in national TB notification rates make it harder to assess the regional impact of migration-related TB. In EU/EEA Member States as a whole, 33% of TB cases were in foreign-born individuals, but the percentage of foreign origin of TB cases within Member States of the WHO European Region with a higher TB prevalence in the host population varied widely, ranging from 0.5% to over 96% of the total TB burden *(48)*. For example, in countries such as Hungary, Poland and Slovakia, foreign-born individuals account for less than 5% of the total TB cases *(30)*.

Fig. 2.3. Percentage of cases of foreign origin among total number of diagnoses of TB (a) and HIV (b) in Member States of the WHO European Region

(a)

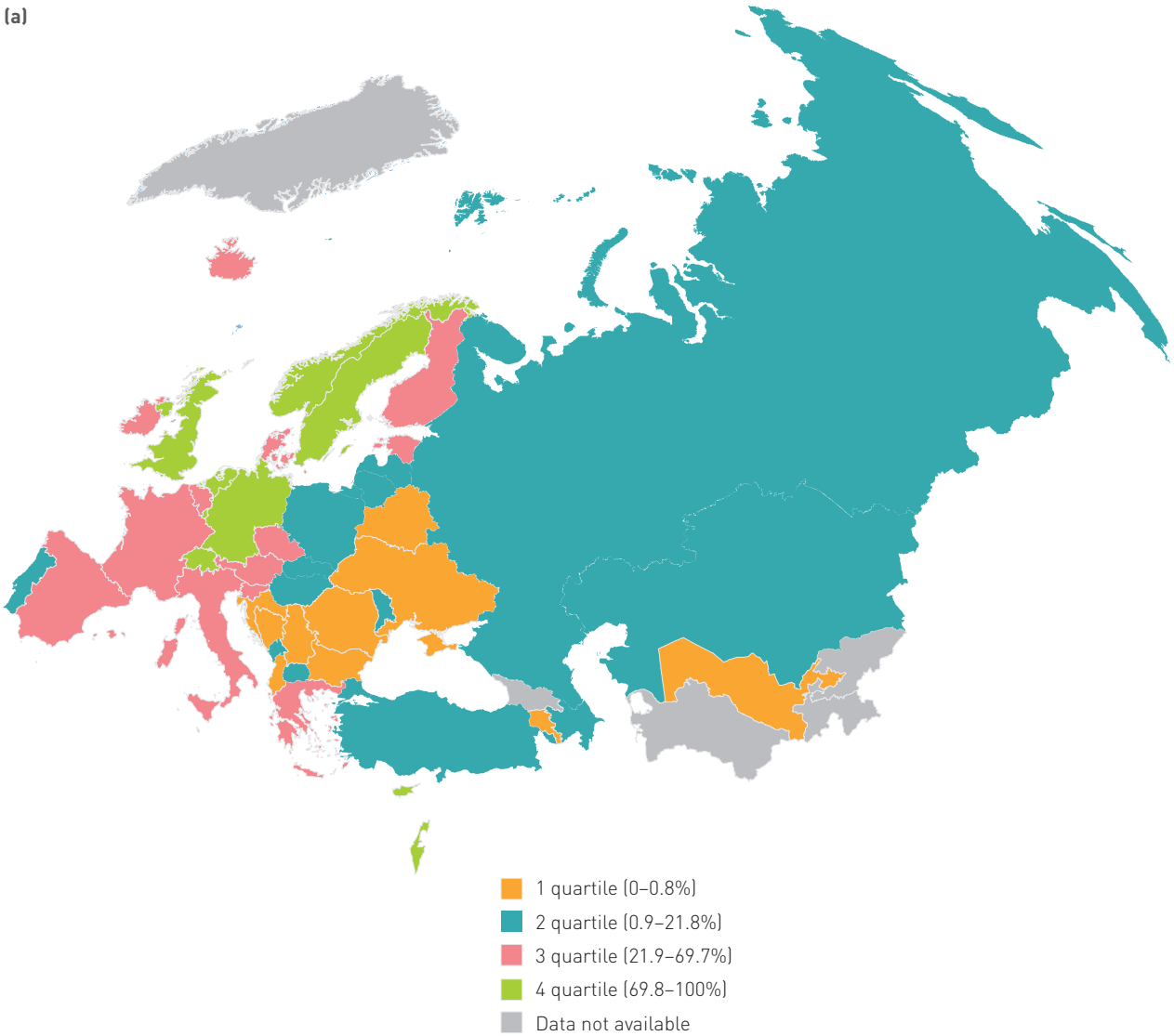
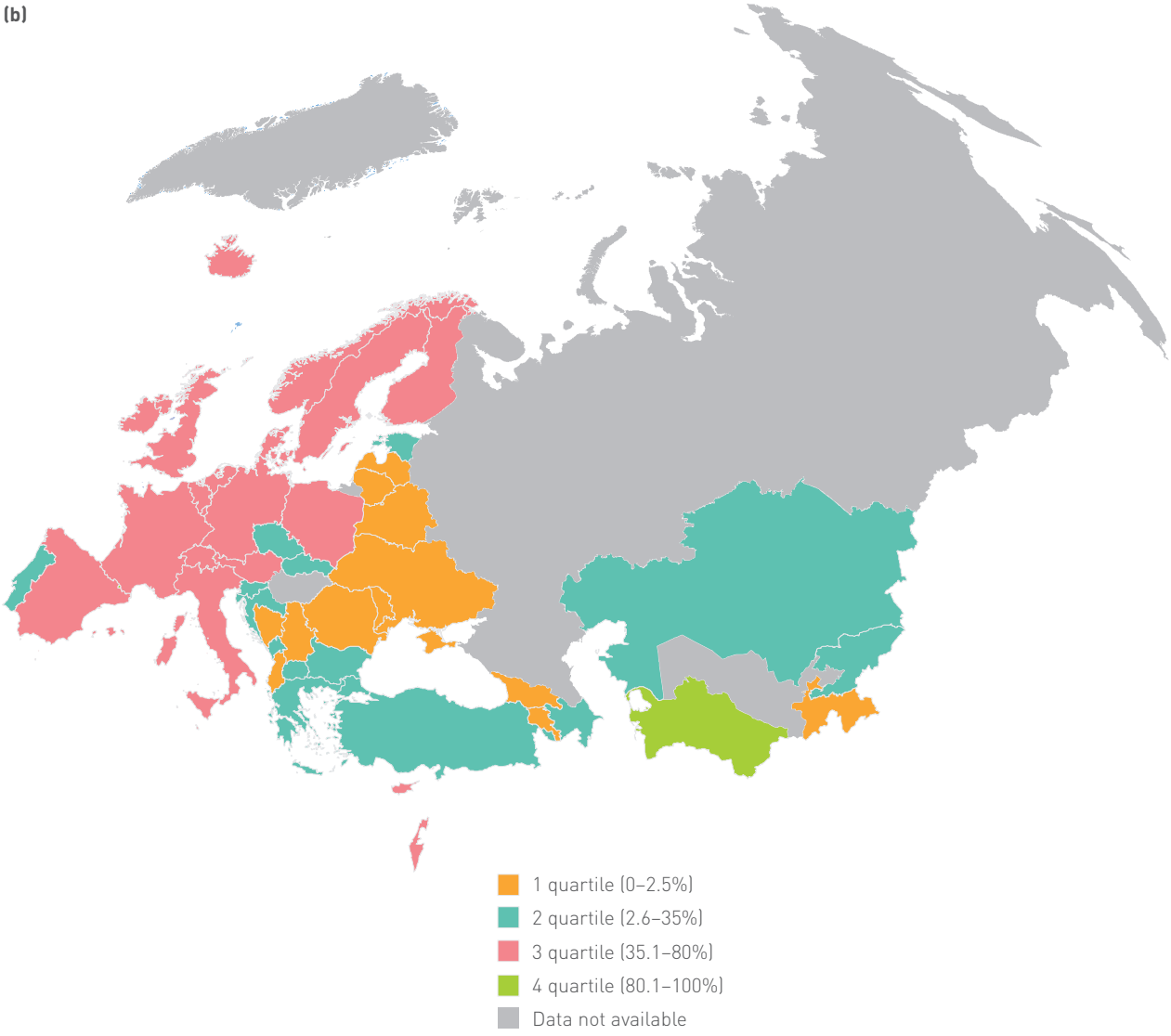


Fig. 2.3. (contd)

(b)



Notes: TB data not available for Georgia, Kyrgyzstan, Monaco, San Marino, Tajikistan and Turkmenistan; HIV data not available for Hungary, Monaco, the Russian Federation and Uzbekistan.

Sources: European Centre for Disease Prevention and Control & World Health Organization, 2017 *(31)*, 2018 *(48)*.

Refugees and migrants arriving from countries with high prevalence of TB are at greater risk of infection *(49)* but the epidemiological and health system impact is less apparent in countries with a high host prevalence (Table 2.1).

Refugees and migrants in the EU/EEA experience a disproportionate burden of MDR-TB compared with host populations, with many individuals originating from countries with a high burden of MDR-TB, such as countries in eastern Europe and central Asia *(50)*. It is thought that overall the proportion of MDR-TB attributable to foreign-born individuals within the EU/EEA could be around 73.4% *(51)*, although there is significant heterogeneity in patterns across the WHO European Region. In countries such as France, Germany, Italy and the United Kingdom, over 80% of diagnosed MDR-TB occurs in foreign-born individuals, while this is less than 5% in countries such as Romania and Lithuania *(30)*. Little is known about the burden of MDR-TB in specific migrant groups and refugees. However, data

detected so far suggest there is only a limited risk for the resident population *(52)*.

Many factors contribute to the epidemiology of TB in refugees and migrants in the Region, including the prevalence of TB in origin and transit countries, the conditions experienced in transit and in reception centres, living and working conditions in the host country, latent TB infection, malnutrition and lack of access to health care *(30)*. The activation of latent infection following arrival in the host country is one of the main drivers of TB among refugees and migrants *(53)*. For this reason, countries that only recently became a destination for refugees and migrants may not observe the impact of activated disease for some time *(54)*. In addition, national health systems may not consistently record refugee or migrant status or the diagnosis of comorbidities. Rates of AMR are rising globally for diseases such as TB and there is concern that increased migration might contribute to this burden in Europe (Box 2.1). Prevention and care measures for TB including cross-border TB control and care are discussed under Preventive care.

Table 2.1. Proportions of TB cases attributed to people of foreign origin in the total population in selected countries

Member State	People of foreign origin among TB case notifications (%)
Malta	96.0
Cyprus	93.3
Sweden	89.8
Slovenia	36.4
Czechia	29.3
Spain	28.5
Estonia	21.9
Ukraine	0.1
Belarus	0.0
Uzbekistan	0.0

Source: European Centre for Disease Prevention and Control & World Health Organization, 2018 *(48)*.

HIV

While it has been estimated that approximately 40% of new HIV cases in the EU/EEA are reported among people who originate outside of the reporting country, there is growing evidence to suggest that a significant proportion of refugees and migrants who are HIV positive, including those who originate from countries of high HIV prevalence, acquire infection

Box 2.1. AMR and migration

AMR occurs when microorganisms change in ways that render ineffective the medications used to cure their infections. This is a major concern because a resistant infection may kill, can spread to others and imposes huge costs to individuals and society *(55)*. Rates of AMR are rising globally and there is concern that increased displacement and migration might contribute to the burden in Europe. Although surveillance for AMR in the WHO European Region is among the most advanced in the world, there are limited data available on the role of displacement and migration on the burden in the Region. Existing evidence suggests that refugees and migrants are exposed to conditions that are favourable for the development of AMR.

A recent review found that the pooled prevalence of any carriage or infection with antimicrobial-resistant organisms was higher in refugees and asylum seekers (33.0%; 95% confidence interval (CI), 18.3–47.6; I^2 = 98%) than in other migrant groups (6.6%; 95% CI, 1.8–11.3; I^2 = 92%). The pooled prevalence of antibiotic-resistant organisms was slightly higher in community settings with large numbers of refugees and migrants, such as refugee camps and detention facilities (33.1%; 95% CI, 11.1–55.1; I^2 = 96%), than in hospitals settings with large numbers (24.3%; 95% CI, 16.1–32.6; I^2 = 98%). The review did not find evidence of high rates of transmission of AMR from refugees and migrants to host populations. In addition to the need for improved living conditions, access to health care and initiatives to facilitate detection of and appropriate high-quality treatment for antibiotic-resistant infections during transit and in host countries, protocols to prevent and control AMR should include measures to address the challenges faced by refugees and migrants *(56)*.

after they have arrived in the Region *(31,57,58)*. This has important implications for those HIV prevention programmes that are focused on pre-arrival risks. The proportion of HIV cases among refugees and migrants within the total population of a country also widely varies geographically across the WHO European Region (Table 2.2 and Fig. 2.3b).

Table 2.2. Proportions of migrants among total number of people living with HIV in selected countries

Member State	Migrants among total number of people living with HIV (%)
Andorra	100
Turkmenistan	100
Sweden	80.9
Malta	74.6
Portugal	35.0
Czechia	30.4
Republic of Moldova	0.0
Ukraine	0.0

Source: European Centre for Disease Prevention and Control & World Health Organization, 2017 *(31)*.

In the 47 Member States of the WHO European Region with available data, 21% of new HIV diagnoses in 2016 were reported in individuals who originated outside of the reporting country: 6% originated from other countries of the Region and 15% from outside the Region *(31)*. Where the location of infection was believed to be known, 10 countries in the east of the Region reported that only 10% of people living with HIV were infected prior to migration. For this 10%, the majority contracted the infection in neighbouring countries of central and eastern Europe *(31)*. This indicates that migration-associated cases are predominantly regional as opposed to intercontinental in the eastern part of the WHO European Region.

A large survey of cases in the EU/EEA between 2007 and 2012 found that more than 50% of HIV-infected migrants were from sub-Saharan Africa *(59)*. As for the general population, certain groups may have increased rates of infection *(60)*. For example, 59% of HIV cases in migrants from Latin America to the WHO European Region were seen in men who have sex with men *(61)*. This pattern was not observed among migrants from sub-Saharan Africa, where heterosexual transmission accounted for 88% of HIV cases *(34,61)*. In terms of newly diagnosed HIV infections in the EU/EEA, refugees and migrants continue to make up a significant proportion, and in some countries more than 50% of new infections are observed in refugees and migrants *(31)*. In Europe, refugees and migrants are more likely to be diagnosed at a later stage of their HIV infection *(31)*. Reasons for this could be discrepancies and gaps in HIV prevention for refugees and migrants originating from countries with high HIV incidence; stigma and discrimination; migrant status and fear of administrative consequences; gaps in HIV testing services among refugees and migrants; and barriers to uptake and lack of understanding of service availability *(35,62,63)*. The process of displacement and migration can create additional vulnerable situations where infections can occur *(64)*, such as exposure to sexual violence (with potential for transmission of sexually transmitted infections (STIs) *(65)*, substance abuse and secondary risk-taking behaviours linked to poverty, isolation and marginalization *(63)*.

Hepatitis B and C

Infections with HBV or HCV varied with the country or region of origin of refugees and migrants *(66–68)*, and prevalence among specific refugee and migrant populations was different across Member States of the WHO European Region (Table 2.3) *(67)*. A higher prevalence of HBV and HCV infection was seen among refugees and migrants from sub-Saharan Africa and north Africa compared with the host population in some countries of the WHO European Region *(69)*.

Table 2.3. Prevalence of HBV infection among migrant populations in the WHO European Region

Country of destination	Region/country of origin	Prevalence of HBV infection (%)
England (United Kingdom)	China	8.5
Germany	Turkey	5.0
Italy	Eastern Europe	6.9–36.7
Italy	Sub-Saharan Africa	7.4–13.9
Netherlands	China	8.7
Spain	Sub-Saharan Africa	8.0–15.0

Source: Coppola et al., 2015 *(66)*.

Prevalences of HBV and HCV in refugees and migrants have tended to reflect the prevalence of infection at their place of origin *(68)*. The rate of chronic HBV infection was more than 10% in those from eastern Asia, the Pacific and sub-Saharan Africa; 4–6% in those from central and southern Asia and eastern Europe; and less than 2% in those from north Africa, the Caribbean, Latin America and the Middle East *(68)*. With the exception of migrants from eastern Europe and central Asia, chronic hepatitis B was more commonly observed in refugees than in migrant populations studied *(68)*. Prevalence of HCV infection was highest among refugees and migrants from sub-Saharan Africa, Asia and eastern Europe. In particular, older migrants had increased risk, with a seroprevalence of anti-HCV antibodies of 2.2–5.6% *(70)*.

Data from 31 Member States of the WHO European Region indicated that 53% of the total refugee and migrant population was born in countries of intermediate/high HBV endemicity (prevalence ≥2%) and 79% in countries of high HCV endemicity (prevalence >1%) *(67)*. Prevalence of chronic HBV infection ranged from 3% to 9% across the 31 reporting countries *(67)*. HCV infection among refugees and migrants from countries of high endemicity ranged from 0.9% in Croatia to 2.4% in Latvia.

Evidence from western Europe suggested that refugees and migrants originating from regions of higher HBV prevalence had greater rates of chronic infection in some countries of destination (Table 2.3) *(66)*. Refugees and migrants from regions of higher HCV prevalence and living with chronic HCV infection in the WHO European Region numbered 300 000–900 000 in 2015 *(67)*.

Tropical and parasitic infections

Some diseases are uncommon in the majority of countries of the WHO European Region, and those assessing and providing care for refugees and migrants should be familiar with the epidemiology and distribution of such diseases. Tropical and parasitic infections (e.g. schistosomiasis, strongyloidiasis and Chagas disease) can also be associated with long periods of latency or chronicity, which can have serious effects on individual health if left untreated *(71)*. Lack of recognition, diagnosis and treatment of latent or chronic infection may be followed by more serious complications, including disseminated infection *(72)*.

The European Centre for Disease Prevention and Control reported a prevalence of 1.4 cases of shigellosis per 100 000 refugees in 29 countries of the WHO European Region. Shigellosis is often endemic in countries of origin or transit. Although shigellosis among refugees presents a very low threat to the total population in the Region, poor hygiene in refugee reception centres can put the refugee population at greater risk, as well as individuals working in these facilities *(73)*.

Leishmaniasis and colonization with antibiotic-resistant Gram-negative bacteria are the most frequently reported infectious diseases in Syrian refugees and migrants in Europe, while scabies, louse-borne relapsing fever, *Plasmodium vivax* malaria and schistosomiasis are most frequently reported among Eritrean refugees and migrants *(74)*. A higher incidence of intestinal parasitic infections has been seen in migrant children compared with the host population in Italy *(75)*. The risk for re-emergence of malaria in Europe is attributed to people in transit from sub-Saharan Africa *(69)*. Risk of re-emergence of malaria is attributed to *P. vivax* malaria and refugees and migrants from countries where malaria is prevalent. This was exemplified by the epidemic of malaria in Tajikistan in 1990–2009, including re-establishment of *Plasmodium falciparum* malaria, which was linked to the influx of refugees and migrants from Afghanistan, as well as re-establishment of indigenous transmission of *P. vivax* malaria in Greece in 2009–2011, which was linked to refugees and migrants from Pakistan *(76–80)*.

While accurate estimates of infections leading to Chagas disease are challenging, as many as 100 000 cases of Chagas disease were identified in Europe in 2011 *(81)*. Global prevalence rates of infection in migrants from Latin America in Europe are around 4.2%, with heterogeneity between specific countries of origin: for example, an infection rate of 18% in migrants from Bolivia and of 2.2% in those originating in Argentina *(82)*. Chagas disease poses the additional risk of blood-borne transmission, and countries hosting large migrant populations from endemic areas may consider introducing transfusion-related questions or screening of blood for transfusion *(72,82)*.

For these diseases, health professionals also need to be aware that they can occur in travellers to destinations where these diseases are endemic, including refugees and migrants and their descendants later returning to the country of origin *(34,43,73,74,81–83)*.

Noncommunicable diseases

Key points: NCDs

- Refugees and migrants appear to have lower prevalence rates compared with the host population for many NCDs on arrival, but prevalence rates, especially for obesity, begin to converge with longer duration of stay.
- In general, refugees and migrants in Europe have a higher incidence, prevalence and mortality rate for diabetes than the host population, with higher rates in women, depending on the country of origin.
- Although generally there is a higher risk of ischaemic heart disease and stroke among the migrant population, there is no clear pattern for cardiovascular diseases and prevalence may be linked as much to socioeconomic factors as to migration-specific factors.
- Although refugees and migrants have a lower risk for all neoplasms except cervical cancer, they are more likely to be diagnosed at a later stage in their disease than the host population in Europe.

In the WHO European Region, NCDs account for nearly 86% of deaths and 77% of the disease burden *(84,85)*. Results vary within studies on the influence that migration has on the NCD burden *(6–9)*. In Spain and Denmark, the prevalence among refugees and migrants for NCDs such as cardiovascular diseases, stroke and cancer were either lower or similar to the host population. Where it was lower over the first few years after arrival, prevalence seemed to converge over time with that of the host population *(4,5)*. Box 2.2 presents results of a survey conducted using the WHO STEPwise approach among Syrian refugees in Turkey to assess NCD risk factors.

Box 2.2. Assessing NCD risk factors in refugees in Turkey

A WHO STEPS survey, a cross-sectional study, on NCDs in the Syrian refugee community in Turkey in 2015 assessed prevalence of several NCDs and five major risk factors and graded overall health risk into low (no risk factors), medium (1–3 risk factors) and high (>3 risk factors). In the adult population (age 18–69 years), risk was low in 0.3%, medium in 41.1% and high in 58.7%. For men aged 18–69 years, 61.3% had high risk; for women aged 44–69 years, 87.1% had high risk. In the age group 18–69 years, 32.6% and 27.7% of Syrian refugees living in Turkey were found to be overweight and obese, respectively, whereas1.4% were underweight. Women were reported to more likely to suffer from overweight/obesity than men (60.3% compared with 56.2%). The prevalence of hypertension was 27.2% and 23.8% for men and women, respectively.

Source: Balcilar, 2016 *(86)*.

This section provides an overview of NCDs that have received the most research attention for refugees and migrants in the WHO European Region and is followed by a section on mental health issues.

Overweight/obesity

Among the adult migrant population in the WHO European Region, evidence shows that duration of stay in the host country can be associated with the development of overweight/obesity *(87,88)*, with an excess among females, especially among north African migrants *(89)*. Additionally, evidence from the Russian Federation seemed to indicate that obesity rates are higher in all groups of migrants living there compared with the non-migrant population *(90)*. Some research indicates that the development of overweight/obesity is dependent on the region or country of origin of the migrants, as migrants from Africa show this

pattern while migrants from Asia do not *(88)*. The development of overweight/obesity has been linked to changes in dietary behaviours, physical activity, social and psychological factors after migration *(88)*.

Although the WHO European Region has improved substantially the availability of comparable data in terms of the prevalence of childhood obesity, particularly in school-age children, notably by implementing the WHO European Childhood Obesity Surveillance Initiative, which involves 42 countries, systematic comparable data on the prevalence of overweight/obesity and diabetes among refugee and migrant children is not yet available. Some evidence suggests that, in Europe, the prevalence of overweight and obesity is higher for migrant children of both sexes from Morocco and north Africa/Middle East *(91)*. Migrant girls in childhood or adolescence from north Africa are seen to have a higher prevalence of overweight and obesity than their male counterparts, reinforcing the observation that there is a gender difference for this health risk *(92)*. (See also Obesity and diabetes in children.)

Diabetes mellitus

In general, migrants in Europe have a higher incidence, prevalence and mortality rate for diabetes mellitus than the host population *(93)*. Migrants to the WHO European Region have been observed to have an increased risk of developing diabetes mellitus type 2, and this development may occur at an earlier age than for the host population in the country of origin *(94–96)*. Some countries in the Region have also recorded more chronic complications of diabetes among migrants, specifically noting that microvascular complications such as nephropathy, diabetic retinopathy and peripheral neuropathy were worse in this population *(93)*.

Mortality from diabetes is higher in some countries, with the rates three times higher for men and four times higher for women who migrated to the Netherlands *(93)*. However, these observations on mortality depend on the country or region of origin of the refugees and migrants. For example, refugees and migrants to Denmark from Africa, Asia and the Middle East had an incidence of diabetes 2.5 times higher than that of the host population *(97)*, whereas refugees and migrants from other European or American countries had an incidence of diabetes 20% lower than the Danish population *(98)*. Evidence from Sweden suggested that migrants from Asia are 3.2 times more likely than the host population to develop type 2 diabetes, migrants from sub-Saharan Africa are 2.5 times more likely and migrants from north Africa/Middle East are 2.1 times more likely *(95)*. Differences between the host and migrant population could result from factors such as better health screening programmes to promote early diagnosis in WHO European countries *(96)*, genetic background, failure to achieve treatment goals, low screening rates, lack of preventive measures, socioeconomic factors and quality of diabetic care *(93)*.

In the WHO European Region, diabetes prevalence is typically higher among female migrants than male migrants, with variations seen among different ethnicities (Box 2.3) *(99–101)*. The higher prevalence of diabetes among women in the WHO European Region has been associated with duration of stay in the country of destination. However, even after multiple generations, female descendants of migrants were less likely than male descendants to reflect the prevalence rates for type 2 diabetes of the host population *(99–101)*. The gender differences observed, plus issues of obesity and diabetes in children, suggest the need for gender-oriented actions to prevent the development of diabetes and promote its early detection among the refugee and migrant population in the Region *(99–101*

Box 2.3. Gender and diabetes

In the Netherlands, a comparison of the prevalence of type 2 diabetes between migrants and the host population showed odds ratios of 5.82 for Ghanaian women and 6.03 for African Surinamese women. Although men of these ethnicities had higher prevalence of type 2 diabetes than native Dutch men, their prevalence rates were lower than for the female migrants. One reason for the differences observed may be variation in body mass index and body fat distribution among the three groups.

Source: Meeks et al., 2014 *(101)*.

Cardiovascular diseases

Data on cardiovascular diseases in the WHO European Region is highly multifaceted as risk factors such as ethnicity and socioeconomic status influence the prevalence and types of disease affecting the refugee and migrant population. Often different patterns are observed for risk factors in different refugee and migrant groups and data between Member States of the Region are often conflicting.

In general, prevalence of ischaemic heart disease varies with migrants' country or region of origin, the country or region of destination and the duration of stay *(102)*. Although results in different studies varied, the general conclusion was that the majority of migrant groups are at higher risk of ischaemic heart disease and stroke than the host population in western Europe, in particular migrants originating from south Asia, eastern Europe and the Middle East *(102)*. Migrants from south Asia were at a high risk for dyslipidaemia and ischaemic heart disease upon migrating to Italy, with men from south Asia having a mortality rate for ischaemic heart disease 2.53 times higher than that of the host population *(103)*.

The general migrant population in Italy was seen to have higher risk of stroke and hypertension than the host population *(104,105)*. Rates of cerebrovascular disease, hypertension and heart failure were higher in migrants from Africa than in the general Italian population *(106)* but Moroccan migrants in the Netherlands had a lower risk of stroke *(107)*.

In some WHO European Region Member States, the rates of acute myocardial infarction, stroke and hypertension in refugee and migrant populations were higher than in the host populations, but this observation was not constant across countries, and it also depended on the country of origin of the refugees and migrants, with those from some countries having lower rates *(107–112)*. Lower socioeconomic status was found to be one of the most significant risk factors regardless of origin *(107,109)*. Consequently, when considering morbidity and mortality linked to cardiovascular diseases among refugee and migrant populations, it is important to recognize the complex interrelation of factors such as refugee and migrant characteristics and socioeconomic status *(107–112)*. It is not clear whether the cardiovascular risks for refugees and migrants converge with those of the host population as their duration of stay extends in the WHO European Region. In Denmark, the hazard ratios for stroke and ischaemic heart disease were lower for refugees and family-reunited migrants within the first five years after arrival in Denmark but then increased *(113)*. However, in the Netherlands, migrants from Morocco and Turkey, as well as those of south Asian Surinamese and African Surinamese backgrounds, had a higher risk for cardiovascular diseases than the host majority population and this risk did not change with duration of stay or cultural adaptation *(114)*.

Cancer

The most significant finding regarding cancer among refugees and migrants in the WHO European Region is that it is more likely to be diagnosed at an advanced stage, which can lead to significantly worse health outcomes compared with the host populations *(115–118)*. Cancer incidence and mortality rates in migrants tended to be lower than the host population upon initial arrival but converged with host prevalence over time *(103,119)*. Similarities in cancer mortality have been observed between migrants and the host population in Denmark *(5)*, and adult migrants in Italy had similar prevalence of colorectal cancer to the native Italian population *(120)*. However, refugees and some migrant groups have higher rates for cancers linked to infectious diseases, for example cervical cancer, hepatic cancer, Kaposi sarcoma, nasopharyngeal cancer, stomach cancer and some lymphomas *(121)*.

It is important to recognize the nuances within datasets regarding the type of migrant, country of origin and/or destination country and the cancer being reported as all influence the observations on cancers in refugee and migrant populations in the WHO European Region *(122)*. Some evidence suggests that the overall incidence of cancer is lower in migrants from low-income countries but specific cancers (e.g. lung, liver and stomach cancer) are prevalent in certain migrant populations, such as those from eastern Europe, reflecting the trends in the country of origin *(123)*. Displacement and migration are social determinants of health and along with other social of determinants of health is likely to influence living and working conditions and thus affect the incidence of cancer. In Denmark, migrant men (born outside Denmark) and men born in Denmark but with at least one parent born outside

Denmark had a lower incidence of tobacco-related cancers such as lung cancer (10% lower) and lower urinary tract cancer (50% lower) *(124)*. However, lung cancer incidence increased among migrant men (born outside Denmark) reaching the levels of incidence in the host population. Liver and stomach cancer had higher standardized incidence ratios among migrants.

There is limited information regarding cancer among refugee and migrant children in the WHO European Region. Data from Turkey *(125)* indicated that refugee children of Syrian origin had comparable incidence of cancer to children in the host population.

Other diseases

There was limited information on other diseases of significance within the refugee and migrant population of the WHO European Region. Data tended to focus only on select Member States, and often there was insufficient information to draw any overall conclusions regarding whether the refugee and/or migrant population differed from the total population.

A number of blood disorders, such as anaemia and sickle cell disease, have been examined in refugee and migrant populations. A study conducted in Switzerland indicated that migrant children can have a higher prevalence of anaemia (iron deficiency) than host children *(126)*. Another study conducted in Germany among young refugees found that the prevalence of anaemia was in accordance with the recent WHO global estimates. The study also found that more women were anaemic than men (27.1% ands. 20.4%, respectively) *(127)*. Sickle cell disease is also commonly recorded in migrant populations, representing over 90% of the cases in Sweden *(128)*.

While there were generally similar incidence rates among migrants and non-migrants in the WHO European Region for inflammatory bowel diseases *(129)*, the rate was higher than expected for migrants coming from less-developed countries, suggesting that environment largely influences the incidence of this disease *(129)*. Evidence from Italy suggested that irregular migrants with kidney diseases had a significantly higher incidence of nephropathy than the host population *(130)*.

Migrant populations with the highest prevalence of multiple sclerosis were from North America and Europe, and those with the lowest incidence were from Africa and Asia *(131,132)*. For migrants of Iranian origin, genetic risk factors and living in high-risk areas can increase the prevalence of multiple sclerosis *(133)*.

Mental health

Key points: mental health

- Prevalence of mental disorders in refugees and migrants shows considerable variation depending on the population studied and the methodology of assessment.
- Risk factors for mental health problems may be experienced during all phases of the displacement and migratory process and in settling in the host country.
- Prevalence of PTSD among refugees who have been exposed to very stressful and threatening experiences is indicated to be higher than in the host populations.
- Prevalence of depression and anxiety tends to be higher than in host populations but variation by migrant group and in the methods used to assess prevalence make it hard to draw firm conclusions.
- Poor socioeconomic conditions, such as unemployment or isolation, are associated with increased rates of depression in refugees after resettlement.
- Migration was also found to be a risk factor for children's mental condition, and unaccompanied minors experience higher rates of depression and symptoms of PTSD compared with other refugee and migrant groups.

Although the experience of displacement and migration can be complex and stressful, prevalence of mental disorders is highly variable across studies and population groups *(14)*. Prevalence in the refugee and migrant population may be lower, similar or higher than that in the general population, depending on the prevalence in the host population *(14)*.

While some refugees and migrants may have experienced risk factors before settling in the host country, there may be an additional psychological burden through worries about family, either left behind in the home country or settling into the new country; poor living conditions; lack of good social integration and cultural attitudes; or unemployment *(134)*. Children and unaccompanied minors can face particular issues, and these are discussed under Maternal and child health.

Because of the complexity of the factors affecting mental health, their interplay and the fact that not all refugees and migrants are exposed to risks to their mental health, the variation within this population is high and it is difficult to draw generalized conclusions about prevalence of mental disorders. However, studies of higher quality tend to show a lower prevalence of mental disorders.

Mental health is highly stigmatized in many parts of the world and concepts of mental and physical health differ culturally. Self-stigmatization can be higher among migrants and affect their health-seeking behaviour, which might lead to higher rates of hospitalization *(135)*.

Depression and anxiety

A comprehensive review from 2016 showed a wide range in prevalence of depression (5–44%) in refugees and migrants compared with the general population (8–12%) *(136)*. Prevalence rates of anxiety disorders in refugee groups also varied widely, from 20.3% to 88% *(137)*. Extended length of time within the asylum application process has been shown to be linked to development of depression and other mental disorders *(138)*. Poor socioeconomic conditions, such as unemployment or isolation, are associated with increased rates of depression in migrants and refugees after resettlement *(14,137,139,140)*.

Post-traumatic stress disorder

Refugees and migrants, especially asylum seekers and irregular migrants, can be exposed to various traumatic experiences in all phases of displacement and migration, not only in their countries of origin *(133,141,142)*. PTSD is a particular form of anxiety disorder with widely varying symptoms, making it difficult to identify and to generalize on the clinical presentation *(14,143,144)*. Refugees who have been exposed to very stressful and threatening experiences show a wide range in prevalence of PTSD (9–36%) in different studies, compared with 1–2% in the host populations *(14,136,145)*. Research with Syrian migrants in Turkey and Sweden estimated prevalence rates of 30% *(146)* and 83% *(147)*, respectively, with a higher risk among women *(147)*. Comorbidity with depression and anxiety is very common and some studies showed that up to 40% of refugees in the WHO European Region with PTSD had clinical depression *(145)*.

Alcohol and other substance use

There is little evidence that vulnerabilities in refugee and migrant populations lead to substance use and abuse, and some studies showed lower rates of substance and alcohol abuse among refugees and migrants, but prevalence of smoking was higher *(148,149)*. In France, migrant men smoked significantly more than the host population and migrant women smoked significantly less *(150)*. A systematic review on substance use among refugees, asylum seekers and internally displaced people did not show clear results *(63)*. The eastern Mediterranean and north African areas have several ongoing conflicts resulting in displacement and migration of people to other parts of the world, including the WHO European Region. Evidence from the humanitarian and post-conflict situations in Region was not conclusive in showing any correlation between substance use and conflict *(151)*. However, existing evidence suggests that factors such as mental health problems, stress of adapting to new environment, unemployment and previous experience of war might contribute to increase in substance use *(151)*.

Migrant women reported lower use of alcohol and tobacco and less drug abuse than non-migrant women *(152)*. In Sweden, male refugees were less

likely to report alcohol abuse but significantly more likely to report drug abuse *(153)*. Reasons for the substance abuse mentioned by refugees from different backgrounds in the Netherlands included coping with difficult memories, psychological stress and stress connected with the long bureaucratic processes *(63)*. An assessment of substance abuse treatment services in 13 European capitals showed that only 10% of services provided specific programmes or services for refugees and migrant populations *(63)*.

It should be examined whether the patterns and types of substance use differ among host and different refugee and migrant populations so that preventive and treatment programmes can be tailored according to those specific needs *(154)*. Although evidence on alcohol and other substance use among refugees and migrants is limited, substance use prevention and treatment should be integrated into services offered to refugees and migrants as part of a well-informed public health strategy to promote the health of refugees and migrants.

Psychosis and schizophrenia

Psychotic disorders have only been assessed in clinical studies and not in population studies, making it impossible to report their prevalence *(14)*. Limited evidence has suggested that refugees have an increased risk of psychotic disorders compared with both the host population and migrants; the elevated risk was more pronounced in refugee men *(155,156)*. Other studies suggest that migration experience and ethnic minority status are less influential than sociodemographic factors and experiences of trauma in childhood *(156,157)*. A large cohort study in Sweden indicated an increased risk for psychotic disorders for those who migrated during infancy and a variation in risk by region of origin, with migrants from Africa having an elevated risk for schizophrenia *(158)*.

Occupational health

Key points: occupational health

- Globally, labour migrants form the largest group of migrants.
- In 2015, around 12% of all workers in the WHO European Region were migrants.
- Conditions of employment vary drastically, as do the health hazards of the jobs and access to social and health protection.
- Male migrants show significantly more work-related injuries than non-migrant workers, whereas numbers in female migrants appear to be similar to those in the host population.

Labour migration is the main form of migration in the central Asian countries of the Region and in 2013 it was estimated that there were around 56.6 million labour migrants in the Region as a whole. Annually, about 1.5 million labour migrants move to work in the Russian Federation, mainly from the poorer central Asian states *(159)*. Labour migrants form a very heterogeneous group: they may be high or low skilled; employed in various areas and under varying conditions; and have temporary, permanent or no right to stay *(160)*. Irregular migrants may have informal work agreements without the social protection of health or social insurance *(159,161)*. Labour migrants may be exposed to discrimination in the workplace, exploitation, psychosocial problems and dangerous working conditions. The most common work-related health problems reported among labour migrants were musculoskeletal, respiratory and mental health problems *(159)*. Work-related injuries were more common among labour migrants than in the non-migrant population: in Czechia, injuries were the top cause for hospitalization among all migrants, and work-related injuries were three times higher for migrants than for the non-migrant population *(162)*. Migrant workers are also more likely to work long hours, in high-risk jobs and without

necessary safety measures and to avoid complaining about hazardous conditions *(159,163,164)*. Some evidence has suggested that there is a gender effect, with male migrants showing significantly more work-related injuries than female migrants, for whom the occupational injury rate was the same as for the host population *(165)*. This might reflect the traditional division of work domains, with men tending to work in sectors with higher physical health risks, such as construction and mining *(159,166)*. However, female migrant workers often work in domestic services or as seasonal farm workers, with only verbal contracts and little opportunity to register complaints or ensure sick leave and occupational safety *(158,167)*.

Some initiatives have sought to improve the health of labour migrants, for example through provision of information campaigns for foreign workers to improve their health and safety issues *(168)* and preventive outreach for infectious diseases (see Preventive care).

Maternal and child health

Key points: maternal and child health

- There is a marked trend for worse pregnancy-related indicators among refugees and migrants.
- Refugee and migrant women are protected from adverse obstetric and perinatal health outcomes through personal factors, such as socioeconomic and educational status, and characteristics of the host country, such as having a strong integration policy.
- Refugee and migrant children may be more prone to health issues related to diet: both malnutrition and overweight/obesity.
- Migration is a risk factor for children's mental health.
- Unaccompanied minors are vulnerable to sexual exploitation and experience higher rates of depression and symptoms of PTSD.

Maternal health care generates particular needs for both migrant and host populations. Compared with non-migrants, most migrant women still face poorer pregnancy outcomes. Maternal and child health are areas where familiarity, comprehensibility, acceptability, availability and affordability particularly affect health-seeking behaviours *(169)*. This section discusses issues of particular concern for refugee and migrant women and children. Children may have had extended periods of inadequate nutrition and lack of routine care during the displacement and migratory process and this can lead to health issues (e.g. lack of full immunization or poor dentition).

Obstetric and perinatal health

While the amplitude and direction of variations in outcomes differ between host countries, migrant origin/status and the outcome examined, there is a marked trend for worse pregnancy-related indicators among refugees and migrants *(169)*.

A recent WHO review *(169)* found that refugee and migrant women had poorer pregnancy outcomes compared with non-migrant women, including increases in pre- and perinatal events such as induced abortions, caesarean sections, instrumental deliveries and complications during childbirth. A study in the Russian Federation found that almost 50% of pregnancies in refugee and migrant women ended in abortion and 10% in miscarriage or stillbirth *(170)*, while African refugee and migrant mothers in Sweden were found to have 18 times more risk of neonate death *(171)*.

Some evidence also indicates a higher prevalence of low birthweight and small for gestational age babies (a proxy for placenta problems) in refugee and migrant women *(172–175)*, with refugees tending to have a higher risk than other migrant groups *(173)*. Studies in Italy and Portugal found increased preterm delivery rates among migrant women *(176,177)*, while other studies found migrants were more likely to have better outcomes for both low birthweight infants and preterm

births *(178,179)*. Other findings also indicated differing incidences of pre-eclampsia between migrant groups and host women. In Norway, for example, the risk of pre-eclampsia was lower for migrant than for non-migrant women but this risk increased with the length of residence in Norway *(180)*.

In the WHO European Region, maternal mortality is higher among migrant women than non-migrant women *(181,182)*. In France, maternal mortality is 2.5 times higher among refugee and migrant women than women born in France, and this rate increases to 3.5 times higher specifically for women from sub-Saharan Africa *(183,184)*. Migrant status has been found to determine maternal mortality rates in data obtained from eastern Europe and central Asia *(185–187)*. Maternal mortality can be reduced with adequate care and medical support, and a number of factors have been identified as protecting refugee and migrant women from adverse obstetric and perinatal health outcomes, including mother's background and origin from a country with high Gender-related Development Index and advanced health care system *(181,188)*; the mother's education level, knowledge of local language and social support network; and length of stay in the host country and that country having a strong integration policy *(182,189–193)*. A Swedish study found an increased rate of potentially avoidable perinatal deaths among African mothers *(171)*. The most common factors identified as resulting in potentially avoidable perinatal deaths were delays in seeking health care, refusal of medical interventions, insufficient surveillance of intrauterine growth restriction, inadequate medication, misinterpretation of cardiography and interpersonal miscommunication *(171,194)*.

Risk factors for poor migrant maternal health include several that are directly related to being a migrant, such as poor living conditions, unemployment, the need to support families and poverty. These risk factors expose women to a range of specific risks including HIV infection, other STIs and TB, as well as dangers from potential trafficking, sex work or forced labour *(12,195–200)*. These risk factors, combined with lower access to family planning and contraception and lower uptake of general gynaecological health care, all contribute to the poorer pregnancy outcomes described above *(30)*.

The combination of obesity and disposition to diabetes among some refugee and migrant women could lead to increased rates of pre-eclampsia and severe congenital anomalies, thus contributing to the higher risk of perinatal mortality *(201)*.

In addition, to physical health problems, many women suffer from mental health problems during or after pregnancy, mostly postpartum depression *(202)*. In Portugal, for example, the risk for postpartum depression is more than six times higher in migrant than in non-migrant mothers *(203)*. Identified determinants of postpartum maternal mental health problems or depression among refugee and migrant women in Europe include social isolation, lack of social/emotional support, language barriers, problems with husband/family, cultural conflict, being a single mother, previous depression or not being in contact with the partner *(204,205)*.

Obesity and diabetes in children

Research in Norway focusing only on refugee and migrant children from a non-western background found a 27% higher prevalence of general overweight (including obesity) and a 50% higher prevalence of abdominal obesity compared with the host population *(206)*. However, a German study that focused on all migrant children and did not differentiate based on country or region of origin showed a prevalence of overweight of 12.7% compared with 6.9% in the host population *(207)*. A higher risk for overweight/obesity was also observed among girl migrants compared with boy migrants *(92)*.

The prevalence of type 1 diabetes in all refugee and migrant children in Norway was found to be dependent on ethnic background: refugee and migrant children accounted for approximately 5% of the total cases in Norway but some refugee and migrant groups had a significantly lower incidence than children in the host population *(208)*. Consequently, generalizing on overweight/obesity and diabetes prevalence in refugee and migrant children and adolescents in the WHO European Region is difficult because of variety in the populations and the destination countries.

Dental health in children

Across the WHO European Region, oral health has been recorded as poorer in the refugee and migrant population than in the host population *(209–212)* and dental care is considered one of the key problems among migrant children *(213)*. Nearly 50% of refugee

children in Switzerland under the age of 5 years had dental caries, compared with 20% in children of the same age group in the general population *(214)*. The increase in the rates of dental caries can be related to inadequate dental care and nutritional deficiencies *(17)*. Vitamin D deficiency has been identified among migrant children in northern parts of the WHO European Region *(215,216)*.

Child and adolescent mental health

The mental health status of refugee and migrant children is often shown to be lower than that of the host population within the WHO European Region *(217–221)*. A meta review of 39 studies from eight different European countries showed that migration status can be postulated as a risk factor for children's mental condition *(222)*, predominately internalizing disorders (PTSD, depression and anxiety) associated with exposure to organized violence and migration stress. Suicide attempts among young migrants in Europe have been shown to be higher than in the host populations *(223)*.

Research is inconclusive regarding externalized problems, such as conduct disorder or hyperactivity *(218,222–224)*, although displaced and migrant children are more likely to be affected *(218,219)*. Refugee and migrant children have been shown to have an increased risk for psychotic experiences compared with children in the host populations *(217)*. Higher rates of psychiatric disorders such as depression, PTSD and anxiety were also found to be more common among children born in the country of settlement to parents born elsewhere than in children of the host population *(218)*.

Evidence from research conducted in Norway, Spain and Sweden on refugee and migrant children's health generally described a lower prevalence of alcohol and substance use among young refugees and migrants in comparison with the majority population *(225)*. One exception was the use of illicit drugs in Sweden, which was significantly higher in refugee and migrant youth than in the youth of the host population, particularly for migrants coming from other European countries. Differences between migrant groups could be observed, with migrants from Asia showing low cannabis use in Norway and low alcohol use in Sweden. A gender difference could also be observed, with girls exhibiting lower drinking and smoking behaviour. A potential explanation for those differences is that norms in the countries of origin of refugees and migrants continue to influence their behaviours *(225)*.

Mental health of unaccompanied minors

Unaccompanied asylum-seeking children form a population at particularly high risk for mental health problems, which can be related to their increased risk for traumatic life events such as conflict-related violence; suffered or witnessed threatening events; physical and sexual abuse; and loss of a close relative or carer *(226,227)*.

In Norway, 48% of unaccompanied adolescents seeking asylum met the diagnostic criteria for a mental illness *(228)*. Unaccompanied minors show higher rates of depression and symptoms of PTSD compared with other refugee and migrant groups *(229,230)* or with children who were accompanied by an adult during migration *(231)*.

While there is still wide variation reported in the prevalence of mental health problems among unaccompanied minors in Member States of the WHO European Region, evidence suggests that post-migration stressors can have as significant an impact on the prevalence of mental health problems as traumatic events before and during their journey *(232)*. Placement in a low-support facility upon arrival in Norway was associated with higher levels of psychological distress, particularly for those minors who were placed in facilities for adults *(233)*. A review assessing nine studies from Europe found that unaccompanied girls experienced higher vulnerability for depression, anxiety and PTSD but concluded that more research was needed to clarify these observations *(234)*. These children are often reluctant to discuss any symptoms of mental illness that they are experiencing, and one in five have delayed presentation *(231)*; consequently, mental health challenges are often long term in this population *(230)*.

Sexual and gender-based violence against unaccompanied children

Unaccompanied minors are vulnerable to sexual exploitation because of their lack of protection and feelings of fear, ignorance, stigma and powerlessness, which prevent them speaking out *(235,236)*. They are often targeted by abusers precisely for these reasons: 72% of detected female victims of trafficking had

experienced sexual exploitation *(237)*. A UNHCR report from 2017 indicated that boys also suffered from sexual exploitation and abuse, often in detention settings, and in higher numbers that often assumed *(238)*. Unaccompanied minors who live with extended family members or unrelated carers experiencing economic hardship are often at an elevated risk because they are likely to be used for financial gain (e.g. through prostitution, child marriage or trafficking) *(235)*. Girls are at increased risk of being pressured into a dependency that does not give them the chance to reject an offered child marriage *(237)*. Sexual violence and child marriage have significant physical, emotional and developmental consequences for children, including early pregnancy, STIs and physical and psychological harm. It is common for girls who marry early to drop out of school *(237)*.

Child maltreatment

There is a lack of conclusive evidence on whether maltreatment of children and adolescents within the family differs in refugee and migrant groups from that in the host populations in the WHO European Region. Refugee children have been overrepresented within child protective services in parts of the Region for physical abuse *(239,240)*, but it is not clear whether this relates to issues such as harsh disciplinary practices within families, poverty and related social risks, bias of reporting professionals or a lack of cultural competence and needed resources *(241)*.

In Switzerland, reported child maltreatment was highest among migrants from non-western countries, followed by western migrant groups and then the host population *(242)*. Refugee and migrant background was related to the socioeconomic and ecological risk factors for child maltreatment, and the distribution of these risk factors varied depending on the migrant context *(242)*.

Sexual and reproductive health

Knowledge about contraception and family planning has been shown to be highly dependent on the country of origin and previous educational attainment. Irregular migrants are at a higher risk of unintended pregnancies *(243)*. A study from Sweden showed that contraceptive use and knowledge about contraceptive methods was significantly lower for migrant women than for the host population *(244)*. The WHO Regional Office for Europe's Action Plan for Sexual and Reproductive Health in 2016 identified this challenge and called upon Member States to establish and strengthen formal and informal evidence-informed comprehensive sex education and organize dedicated services to promote access for refugees and migrants to sexual and reproductive health services *(245)*.

Female genital mutilation

Female genital mutilation is not a traditional practice in the WHO European Region and is illegal in most EU countries *(246)*. However, it does occur in certain groups and migrating women may also have been cut in their country of origin *(247,248)*. Female genital mutilation has no health benefits and can lead to a number of health complications, such as pain during intercourse or the birth process, psychological problems and postpartum complications *(249,250)*. A lack of education, being a refugee or a migrant and being a member of certain religious groups can be associated with female genital mutilation *(251)*. Recent evidence indicates that longer duration of stay in a host country is positively associated with rejecting the practice *(252)*.

Sexual violence

Sexual violence is a serious public health and human rights problem with both short- and long-term consequences for a person's mental, physical, sexual and reproductive health. Many refugees, asylum seekers and irregular migrants experience sexual violence in transit settings but also in countries of destination *(238,253–255)*. Because of a strong stigma attached to the topic, low reporting rates and little research in the field, it is difficult to estimate prevalence. The lack of stable housing or lack of a residence permit increases vulnerability, the risk of a precarious living situation and the risk of victimization *(256)*. Sexual violence can also pose the risk of STIs *(257)*. In times of conflict, sexual violence often increases and puts women, men and children at risk *(258)*, particularly children without a carer.

Many refugees and asylum seekers have experienced sexual violence after their arrival in Europe *(259)*. Trafficked individuals, both children and adults, often experience serious sexual violence. Some refugees and migrants are at increased risk of sexual exploitation; while women and children carry the major burden of sexual violence, men and other groups, such as homosexuals, bisexuals and transgender individuals, must also be considered *(238)*. Evidence on sexual violence against refugees and asylum seekers in

asylum reception facilities in seven different European countries showed that professionals knew about existing support structures and preventable measures but residents often had little awareness of these; both residents and professionals said that the number of sexual violence cases could be reduced by more and adequate preventive measures *(255)*.

Sexually transmitted infections

There is limited evidence available for STIs in the refugee and migrant population in the WHO European Region *(61)*. Some studies find a higher prevalence of STIs in refugee and migrant women *(260)* while others find the prevalence to be similar to that of non-migrants *(261)*. Research on STIs often focuses on HIV. However, it is important to research the situation for other STIs as there has been a constant rise in the rates of diseases such as gonorrhoea and syphilis in the Region *(262,263)*. In 2010, 11% of gonorrhoea cases and 7% of syphilis case were in migrants in the EU/EEA: 46% of migrants with gonorrhoea came from another European country, 18% from South America, 13% from North America, 11% Asia and 10% from Africa; and 55% of migrants with syphilis came from another European country, 13% from Asia, 11% from Africa, 11% from South America and 9% from North America *(61)*. A low participation rate in screening programmes for human papillomavirus and lower immunization rates led to higher rates of more advanced stages of the diseases linked to the virus at the time of diagnosis *(44,264–266)*. Some interventions have specifically targeted migrants to increase awareness of STIs, for example labour migrants (see Preventive care) *(267)*.

Health care organization and delivery

Key points: health care organization and delivery

- The right to health is often restricted among the refugee and migrant population based on legal status.
- Irregular migrants and those who are being trafficked often have increased difficulty in accessing health care in the WHO European Region.
- Utilization of primary care services is affected by the organization of the health system and whether payments are required at access.
- Provision of screening and health care for refugees and migrants at borders, who might require it, is an important step towards ensuring their health needs as they move on into host communities.
- Similar to the host population, delivering high-quality and appropriate health care to refugees and migrants requires health information systems that collect accurate and relevant data on their health status and health needs.

Health care organization and delivery play a large part in promoting refugee and migrant health. This topic encompasses a broad range of multilevel policies, programmes, measures and cooperation, and these vary greatly throughout the Region. Large population movements pose specific challenges to health systems that require an understanding of the context as this will affect the approach chosen from country to country. Efforts should be directed towards addressing the specific health needs of refugees and migrants, especially for the most vulnerable groups such as children, pregnant women, the elderly, people with disabilities and victims of torture. Sexual and reproductive health issues, gender-based violence and mental health and care should be the top priorities for attention.

This section will cover entitlement to services for migrants in the WHO European Region before considering their utilization of primary care. Preventive care strategies that either exist or are recommended are covered (screening, cross-border health care and immunization programmes) plus the health information systems that enable monitoring and promotion of refugee and migrant health.

Entitlement to services

The 1946 Constitution of the World Health Organization was the first document to articulate that the right to health is an essential component of human rights *(268)*; it stated that the right to health and health care was universal, fundamental and inalienable and could not be made

dependent on conditions such as nationality or legal status *(269)*. Part of the right to health is that all individuals should enjoy access to systems of health protection that promote the prevention, treatment and control of diseases, access to medication, and equal and timely access to health services, among other things *(268)*.

Although the right to health and, therefore, the right to health services should be universal, data from the WHO European Region indicate that the right to health is often restricted among the refugee and migrant population based on legal status and there are large variations across the Region (Box 2.4) *(270)*. Children and pregnant

Box 2.4. Migrant Integration Policy Index (MIPEX) Health strand for the WHO European Region

Significant variation in the level of entitlement to health care services was identified in the MIPEX Health Strand for 2015 for 34 Member States of the WHO European Region *(270)*, with the following provisions for asylum seekers:

- **conditions for inclusion:**
  - *unconditional inclusion*: 16 Member States (Belgium, Croatia, Denmark, France, Germany, Iceland, Italy, Luxembourg, the Netherlands, Norway, Romania, Spain, Sweden, Switzerland, the former Yugoslav Republic of Macedonia and the United Kingdom); and
  - *conditional inclusion* (often residence in reception centres or designated areas): 18 Member States (Austria, Bosnia and Herzegovina, Bulgaria, Cyprus, Czechia, Estonia, Finland, Greece, Hungary, Ireland, Latvia, Lithuania, Malta, Poland, Portugal, Slovakia, Slovenia and Turkey);

- **extent of coverage:**
  - *identical care to nationals*: 15 Member States (Austria, Bulgaria, Czechia, Estonia, France, Greece, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Norway, Spain, Turkey and the United Kingdom);
  - *care beyond emergency care but not matching the entitlements of nationals*: 17 Member States (Belgium, Bosnia and Herzegovina, Cyprus, Denmark, Finland, Iceland, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden, Switzerland and the former Yugoslav Republic of Macedonia); and
  - *emergency care only*: two Member States (Germany and Hungary);
- **special exemptions from restrictions:** treatment of infectious disease; antenatal and/or perinatal and/or postnatal care; care for minors and care for vulnerable groups may be exempted from the above restrictions (Member States in which there are no restrictions on entitlements for asylum seekers are not listed here):
  - *three or more of the above exemptions granted*: 13 Member States (Belgium, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, Greece, Portugal, Romania, Slovenia, Sweden and Turkey); and
  - *one or two of these exemptions granted*: 11 Member States (Austria, Bosnia and Herzegovina, Czechia, Germany, Hungary, Iceland, Latvia, Lithuania, Poland, Switzerland and the former Yugoslav Republic of Macedonia);
  - *none of these exemptions granted*: two Member States (Malta and Slovakia).

For migrants with valid permits to stay, the provisions are:

- *same entitlements as for residents*: 10 Member States (Belgium, Denmark France, Germany, Italy, Luxembourg, the Netherlands, Sweden, Switzerland and the former Yugoslav Republic of Macedonia);
- *reduced entitlements compared with residents*: several Member States, with slightly reducing entitlements in Estonia and Portugal, new restrictions in the United Kingdom and limited entitlements in central European countries with few migrants;
- *only emergency care provided by the state*: one Member State (Cyprus); and
- *no clear legislation formalized*: one Member State (Malta).

Note: data presented are from the MIPEX Health Strand 2015 *(270)* and any recent developments will not be reflected here. For detailed information, please refer to MIPEX Health Strand 2015.

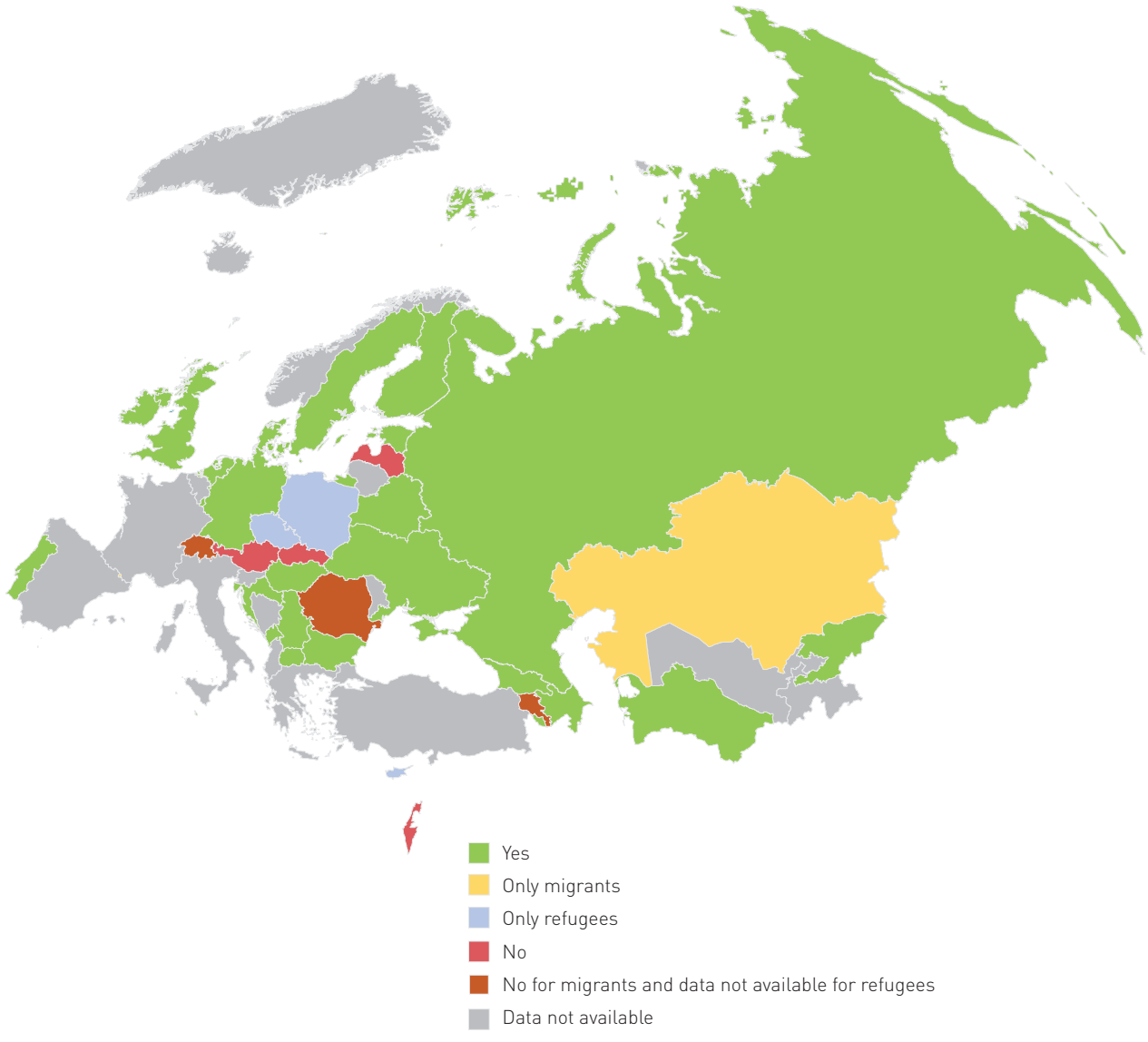
women are often singled out to receive free health care but this is not always achieved (Fig. 2.4) *(271)*.

Two conflicting trends have been occurring across the WHO European Region: attempting, on the one hand, to guarantee human rights by acknowledging the specific health needs of migrants and, on the other hand, to control migration flows and enforce policies restricting their right to health. The lack of consistency in strategies addressing these issues has led to a flawed rights-based approach, an obstacle to potential coherent policy and negative outcomes for migrants *(195)*. The 2016 Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(272)* has influenced positive changes regarding the inclusion of refugees and migrants in national health policies (see Chapter 3).

Irregular migrants

There is a high degree of variability in the right to health care for irregular migrants in the WHO European Region. While health care should be available at all levels no matter the administrative status of the person seeking treatment, there are frequently legal

Fig. 2.4. Free care for refugee and migrant children in the WHO European Region



Source: WHO Regional Office for Europe, 2018 *(271)*.

restrictions barring irregular migrants from enjoying full and effective access to services. There is generally also a lack of health care policies at the national level that address this issue *(12,273)*.

National laws can conflict with international laws in promoting the fundamental right to health if a person's migrant status is used to restrict entitlement to national health care services *(12,269)*. Frequently, irregular migrants do not have access to antenatal and postpartum health care services and are often limited to emergency care services.

The policies for health services for irregular migrants vary greatly in the Region from no access to full access *(12)*. Some countries in the Region do not provide basic access to emergency medical services for irregular migrants, with a few exceptions granted on public health grounds, whereas other countries provide partial or complete health care coverage for irregular migrants under specific circumstances *(270)*.

There are some practices at regional and local levels throughout the WHO European Region that protect irregular migrants. These include the prohibition of reporting migrant status, anonymous medical cards, free health care, language and cultural mediation services, the expansion of training programmes for health care workers, creation of systematized guidelines and development of health policies with migrants' input *(273)*.

Human trafficking

Human trafficking is a lucrative crime that exploits women, children and men, and it can take many forms, including for forced labour, sexual exploitation, forced begging, child soldiers, organ removal, sham marriages, fraudulent schemes and pornography *(274,275)*. While the exact numbers of people trafficked are not known, estimates show that there are millions of victims of human trafficking in the world today. According to the United Nations Office on Drugs and Crime, children make up almost one third of all human trafficking and 79% of all victims are women and girls *(275)*. Given the hidden nature of trafficking, available data are limited and most likely underestimated. Recent estimates indicate that there are around 50 000 trafficking victims in the WHO European Region. While the global average suggests that a majority of trafficking victims are women and girls, there are regional differences in some areas. In eastern Europe and central Asia, for example, men represent the majority of reported victims and in the Mediterranean region children and youth are increasingly becoming victims *(237,275)*.

The key international legal treaty committing governments to combat trafficking is the Palermo Protocol to the United Nations Convention against Transnational Organized Crime *(276)*. Conventions from the ILO on forced labour may also sometimes be applicable, in particular in relation to trafficking of children. WHO supports countries in combating human trafficking and strengthening health systems responses within its framework for addressing violence against women *(276)*.

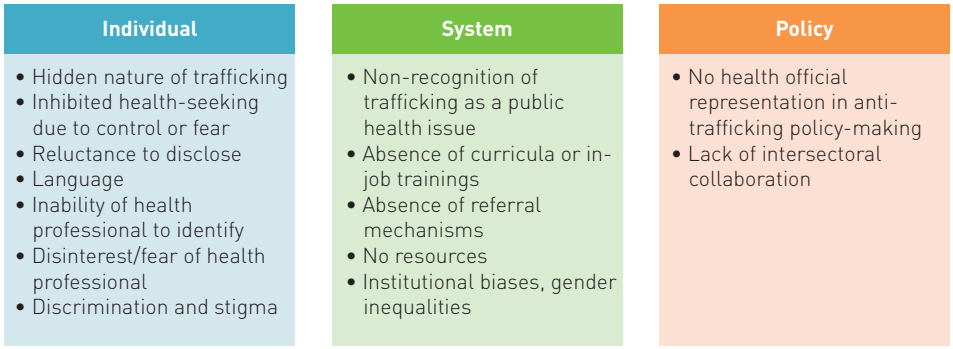
The health effects of trafficking (e.g. from physical, psychological and sexual abuse) and the health needs of trafficking victims mainly relate to poor mental health, depression, PTSD, suicidal thoughts and substance use (drugs, alcohol); violence-related injuries; and reproductive health needs, unwanted pregnancy and STIs *(277–280)*.

While both men and women reported sexual violence, the majority of the support services, especially among refugees and migrants, only address female victims, and services are often connected to maternal and reproductive health clinics. This increases the barriers for male victims of sexual violence to receive help *(259)*.

While there are few studies on victims' access to health services while being trafficked, a recent study in the United Kingdom concluded that about 20% of victims had some form of health care access *(281)*. In a survey of health professionals, about 13% of hospital personnel reported having (or suspected they had) treated a victim of trafficking (20% in maternity wards) *(282)*. Migrant home care workers in Israel, who are predominantly women, were found to be particularly vulnerable to abuse and exploitation at the workplace *(283)* and the intersection between gender, social status and the dependency associated with irregular status was considered to increase their vulnerability.

Fig. 2.5 illustrates several of the dimensions to the barriers faced by the health system to better engage

Fig. 2.5. Barriers to better health system engagement in counter trafficking



Source: based on the analysis presented in Macias Konstantopoulos et al., 2013 *(284)*.

in countering trafficking but as frontline health professionals may be the sole public servants to meet victims of trafficking, the health system has a responsibility to act – as it should for victims of other crimes, exploitation and violence. Both trafficking victims and the victims of these crimes may have limited access to the justice system and would benefit from the intervention of the health system *(278)* with policies such as:

- embedding trafficking-prevention strategies in community health programmes;
- supporting victim identification, promoting safe solutions and building trust;
- ensuring that victims receive trauma-informed and culturally appropriate care;
- promoting accessible models of care, one-stop shops and effective referral pathways;
- providing psychological therapy and empowerment for victims; and
- collaborating with justice and social sectors to combat trafficking and support victims.

Unaccompanied minors are at increased risk for abduction, trafficking for sale and exploitation, and illegal adoption. A report from the United Nations Children's Fund in 2017 on unaccompanied minors using the Mediterranean route to Europe found that children and youth were far more at risk of exploitation or trafficking than adults *(237)*. The risks were exacerbated if surveillance at borders was insufficient, if violations of children's rights already existed and if there was easy access to the child *(235)*. Such children may also be recruited or taken into armed forces, leading to major health consequences *(235)*. Children migrating unaccompanied can face death and disability, detention by authorities, early/forced marriage *(235)*, physical and sexual violence *(285)*, starvation *(286)* and barriers to accessing physical and mental health care *(237)*.

Primary care

The Alma-Ata Declaration considered primary health care as the core element to attainment of the goal of achieving health for all *(287)*. On the occasion of reaffirming the commitments expressed in the Declaration, it is important to recognize and emphasize the health needs of refugees and migrants and the role primary health care has to play in promoting their health.

Health care systems and the organization of health services differ substantially in both methods of delivery and methods of financing within the WHO European Region *(288)*. National health insurance covers care within public health systems but private insurance or direct out-of-pocket payments can be required *(289)*. Access to primary health care services for refugees and migrants varies across the WHO European Region and also within national boundaries *(12,13,159)*. Consequently, it is difficult to make generalized statements or draw conclusions regarding access to primary care for the whole Region.

Generally, access to health care services depends on the person's legal status and usually migrants

having the required residence permits follow the same pathways and services as the host population. Migrant workers may have health coverage through their employers *(13)*. State systems may be ineffective or inaccessible and reliance on nongovernmental organizations (NGOs) to bridge gaps in communication and access is high *(13)*.

The utilization of services by migrant groups has been shown to differ from that of the non-migrant population but this does depend on factors such as the motivation for migration or duration of residence. A systematic literature review of migrants' health service utilization in Europe showed underutilization of screening services by migrants in general but inconsistent patterns for other health care provision, including primary care *(290)*. Gaps in services, barriers to service use and recommendations are presented later in this chapter.

Preventive care

Immediate health and medical needs among refugee and migrant populations derive from those present in the country of origin and those resulting from the displacement and migratory process. Dealing with these needs as soon as possible makes sense both for individual health and for effective use of health care systems. Preventive care includes health services that are used to prevent illness and other health problems or to detect them at an early stage so that treatment can be introduced when it works best *(291)*. Typical examples of preventive care are screening and health checks, immunization, patient counselling and health education and promotion (Box 2.5) *(13,292)*. Cross-border assessment and provision of health care is an important aspect of preventive care targeting those migrating across the Region. These aspects are considered in more detail here.

Box 2.5. Intervention to reduce STIs in labour migrants in transit

Approximately 800 000 Tajik migrants live and work in the Russian Federation. The TRAIN (Transit to Russia AIDS Intervention with Newcomers) project provided information on help seeking and community supports in Moscow, spousal communication about HIV and STI prevention, and communication with community members about STIs. The intervention took place on a train from Tajikistan to Moscow on which most Tajik labour migrants journeyed to work in the Russian Federation. Two questionnaires on family and reproductive health and on family and labour migration collected information from Tajik (mostly male) migrant workers in the Russian Federation and their partners at home *(267)*.

Reproductive and sexual health was clearly an important issue for a significant proportion of Tajik labour migrants in the Russian Federation: 38% made at least one visit to a doctor related to reproductive health problems, although only 23% of their spouses in Tajikistan had contacted a doctor about reproductive health *(267)*. The surveys showed that 9% of Tajik labour migrants in the Russian Federation had a history of an STI in the three years before the questionnaire was issued (2009–2011) and 11% of their partners living in Tajikistan also had a history of STIs. Almost half of the Tajik labour migrants (48%) had sexual contacts other than their spouses (including commercial sexual contacts while working in the Russian Federation): 13% had frequent sexual contacts and 35% had rare sexual contacts.

Screening

Targeted screening of at-risk populations may be considered as a component of the comprehensive assessment of health, particularly for arriving refugees and migrants (see below) *(293)*. Screening should be non-discriminatory, non-stigmatizing and carried out to the benefit of the individual and the public; it should also be linked to access to treatment, care and support. Screening should respond to appropriate risk assessments, have its effectiveness evaluated and be provided on a voluntary basis with ethical attention to confidentiality *(293)*. The delayed participation of migrants in screening programmes can lead to a later detection of diseases linked to older age *(294,295)*. For example, refugees and

migrants are often diagnosed later with dementia and also get medication prescribed later and to a lesser degree *(296)*. Limited access to health care services because of worries about legal status can put irregular migrants at risk, particularly elderly migrants who may be more needful of services because of their advanced age *(17)*.

A literature review including 27 centres across different European countries showed that women from minority ethnic groups were not adequately addressed and included in breast cancer surveillance programmes *(297)*. Increasing active outreach to those communities and assessing the needs of the women to make systems more culturally sensitive would help to ensure that migrant women take advantage of the existing surveillance programmes for breast cancer.

Screening and diagnostic tests for HCV and HBV are important to detect possible infection and determine the stage of progression of the disease and promote treatment *(298,299)*. The identification and treatment of affected refugee and migrant populations will support global strategies for the elimination of viral hepatitis *(300)*.

Screening and health provision at borders

The immediate health and medical needs of arriving refugees and migrants fall into two categories: those present before the refugees and migrants began their journey and those resulting from the displacement and migratory process. Both may create situations where arriving refugees and migrants need urgent medical care and attention. Refugees and migrants with pre-existing or previously unknown conditions may not have had access to medical attention or treatment before or during their travel and may arrive needing treatment. In addition, the displacement and migratory journey itself may have exposed refugees and migrants to violence, trauma and injury, adverse conditions, lack of adequate nutrition and other transportation-associated risks *(301)*. Consequently, health assessment for newly arrived refugees and migrants represents a crucial challenge for European countries, given the increased rates of population movements to Europe *(31)* and the consequent implications for health systems *(302)*. Health centres are not always present or can be very limited at the border or upon reception and may be overwhelmed if there is a sudden influx of people. Across Europe, there is considerable variation in terms of health assessment approaches and best practices *(303)*.

Several countries in the WHO European Region, particularly those considered the first arrival points for refugees in the Region (e.g. Croatia, Greece or Italy), provide health screening services for infectious disease prevention, collect data on infections and have surveillance systems that are regulated by law and set standards *(304)*. Some Member States have developed national guidelines for screening of refugees and migrants at borders *(305)*. However, a lack of financial and human resources often limits the screening available for migrants upon arrival in some border countries, such as Greece *(306)*.

The most frequently screened diseases among newly arrived migrants are communicable diseases, and TB in particular. For example, a study showed that among 15 EU/EEA countries with an implemented screening programme, TB was the disease most commonly screened, followed by HBV, HCV and HIV infections, other STIs, and vaccine-preventable diseases *(67)*. Similarly, among eight non-EU countries of the Mediterranean basin and Black Sea, TB remained the most screened disease, followed by HIV, HBV and HCV infections, and other STIs *(307)*.

The WHO European Region has established a minimum package for cross-border TB control and care based on the Wolfheze workshops, with the cooperation of national TB programme managers. The aim of the package is to foster coordination between non-EU and EU countries within and outside of the WHO European Region and to protect the right to health and continuation of care regardless of legal status. All Member States have been recommended to have sufficient funding from government and health insurance organizations to provide diagnosis and treatment for all *(308)*. A regional fund has been suggested, with particular emphasis on irregular migrants, student migrants and seasonal workers. Service delivery should be culturally competent and should promote the prevention, diagnosis, treatment and control of TB at the first point of contact, as well as continuity of care and confidentiality. Surveillance and monitoring across borders as well as supportive environments are important to reducing the burden of TB in the Region *(308)*. Additionally, WHO and the European Respiratory Society have implemented a set of tools to help in the management of cross-border TB

treatment in migrants *(108,309)*. The approaches used for detecting active TB are still debated. A systematic review assessing the effectiveness of TB screening methods and strategies based on chest radiography in EU/EEA countries reported relatively low yields from screening for active TB compared with other types of active case-finding, such as contact tracing *(310)*. Another systematic review concluded that screening at ports of entry through active searching for TB symptoms may be more effective in identifying active TB than passive screening *(311)*. Despite the limited availability of evidence, TB blood tests appear to be cost-effective for identifying latent TB in high-risk groups, such as immigrants from high-incidence countries and their close contacts *(30)*.

A more comprehensive package of care and surveillance has been recommended for those Member States on the borders of the WHO European Region plus strengthened health information systems in order to effectively and efficiently respond to the health needs of newly arrived refugees and migrants *(84)*. According to WHO, newly arrived refugees and migrants frequently have health problems such as accidental injuries, hypothermia, burns, untreated NCDs, pregnancy and birth complications, plus problems related to sexual violence and psychosocial disorders *(312)*. Children are at particular risk of respiratory, skin and gastrointestinal infections.

Lack of systematized data collection and sharing of information between reception centres is also a challenge *(313)*. Addressing these challenges is an important step towards ensuring that the health needs of refugees and migrants arriving at the borders of the WHO European Region are addressed as efficiently as possible.

Immunization programmes

Immunization is one of the most effective public health interventions for preventing outbreaks of, and controlling, infectious diseases *(314)*. While most refugees and migrants do come from countries with immunization programmes, there are a number of reasons why they may not be fully protected *(36)*. An accumulation of risk factors for vaccine-preventable diseases among the refugee and migrant population has created a need for systemized immunization plans to prevent any threats to public health and protect the health of the refugee and migrant population. Current recommendations are that newly arrived refugees and migrants should be vaccinated according to the national immunization schedule of the host country if they will be residing there for more than seven days *(315)*. However, often refugees and migrants will move from country to country before they are settled in a destination country and methods to register, track and share immunization data between countries vary. National immunization programmes in the Region generally lack targeted recommendations for refugees and migrants, with these occurring only in 11 Member States (see Fig. 2.2) *(36)*. Administrative barriers regarding entitlement to free health services, and lack of knowledge by providers and users, can result in many refugees and migrants failing to receive immunization services. In particular, irregular migrants may fail to access programmes through fear of administrative or legal consequences. Other barriers include social isolation, poverty and literacy levels of refugees and migrants; inadequate training of health care professionals; lack of routine data collection and evaluation; and lack of finance and resources *(36)*.

Preparedness and contingency planning

Preventive care also encompasses being prepared for, and being able to respond to, unexpected demands on health care provision. Contingency planning refers to the routine monitoring and identification of vulnerabilities, risks and health system capacities in order to plan and implement response mechanisms and minimize or eradicate risk. In this context, risk mitigations include all actions taken to reduce the likelihood and intensity of exposure to hazards that threaten population health. Recommended actions to be taken when implementing contingency plans in the context of displacement and migration are vaccinations, vector control, alert and response systems, infectious disease control, enhanced sanitation and hygiene, improved surveillance and early warning, greater provision of essential nutrients and clean water, and ensuring access to medication and medical supplies *(316)*. Screening for communicable diseases is one component of contingency plans for large arrivals of refugees and migrants.

Regional good practice has underlined the importance of effective contingency planning, including

full funding at national and regional levels and provision of specific services such as trained interpreters. Patient consultation processes on arrival of refugees and migrants should be strengthened to include evaluation of their experiences before migration, the potential hazards they may have been exposed to in their country of origin and their experiences during the displacement and migration process. Organization of services in collaboration with NGOs may provide the advantage of increasing the cultural sensitivity of services aimed towards migrants *(316)*.

WHO assistance in assessing contingency plans

The WHO Regional Office for Europe has cooperated with national authorities in 12 Member States receiving large volumes of refugees and migrants in assessing contingency plans. These assessments use a unique toolkit developed through the Regional Office's Migration and Health programme in collaboration with other United Nations agencies *(317)*. The arrival of large numbers creates many problems, involving rescue and logistics, border security, public health and health care provision, documentation, administrative processing, refugee status determination and protection of the vulnerable (Box 2.6). Resources or extra capacity may need to be sought from international sources *(318)*. Planning needs to consider the methods by which the refugees and migrants mainly arrive: primarily by sea *(319)*, primarily over land, or both. These differences are important for planning and preparedness as the number and nature of national and civil society sectors involved can differ with the method of arrival. Maritime arrivals, for example, may involve military, naval, NGO and search-and-rescue components, increasing the need for chain-of-command and coordination components within contingency planning *(320)*. Coordinated, multilateral communication needs may be more complicated, particularly

Box 2.6. Key findings and recommendations from assessments of health system capacity to manage sudden, large influxes of refugees and migrants

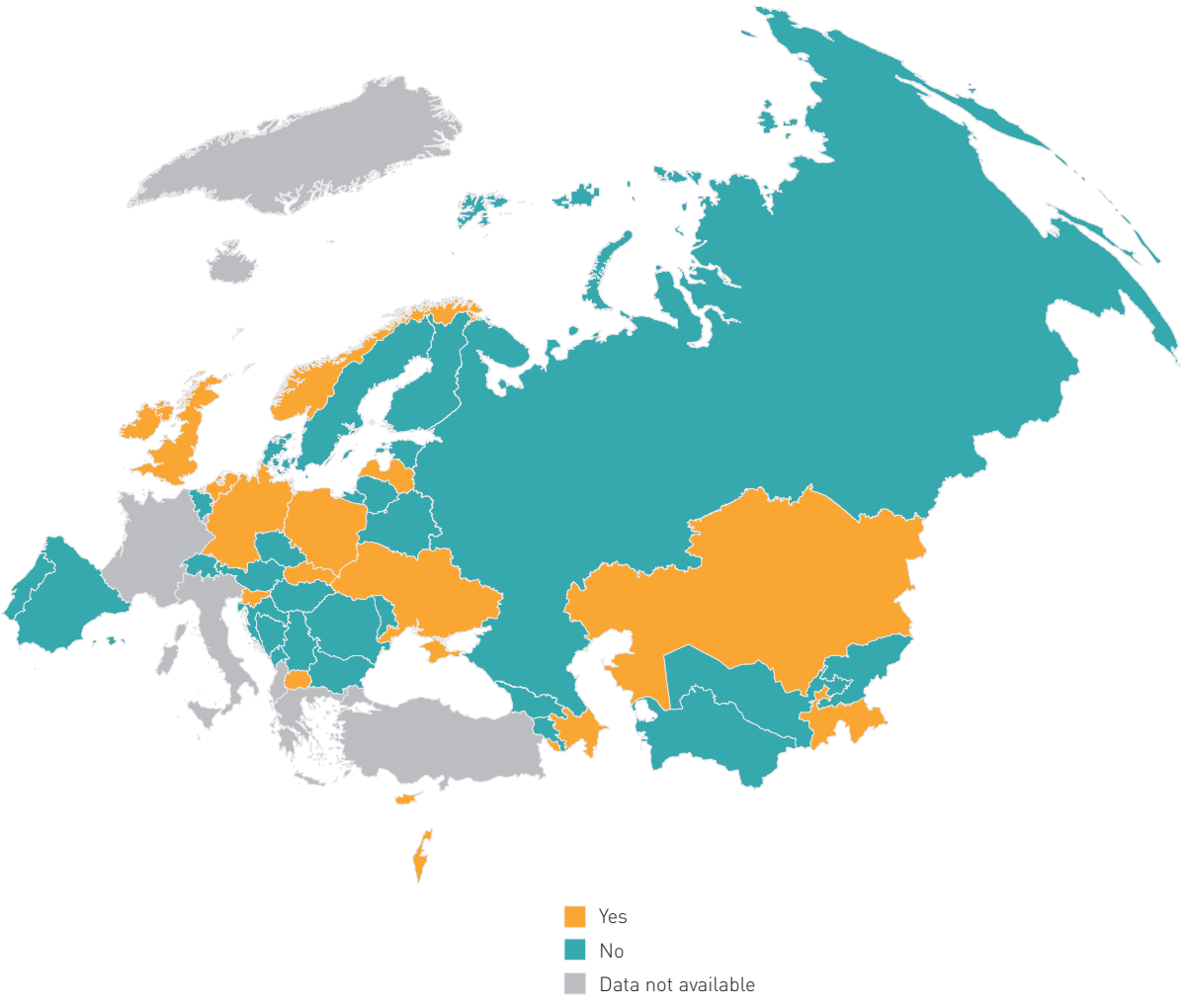
- Advanced planning and coordination of service delivery is essential among national departments, agencies and organizations involved in the operations. The understanding and definition of roles and responsibilities of all involved are critical components of the contingency planning process.
- Initial medical assessments should be coordinated with civilian health authorities if medical services of one of the emergency services are being used.
- The human and fiscal resource demands on the health workforce need to be considered, particularly in situations of sustained high-volume arrivals.
- Adequate provision of interpreters and translation services as well as cultural mediators and facilitators should be planned for in the health sector.
- National planning should include the hospital sector as some new arrivals may require referral and complex or longer-duration care.
- An integrated communications strategy should encompass clear risk-communication components to mitigate fear and anxiety among health care providers, the host population (including the media) and the refugee and migrant arrivals.
- Clear immunization guidelines and health and sanitation standards should exist for reception, holding and processing facilities.
- If possible, medical and public health information (e.g. immunization status, disease surveillance) should be integrated into national health information systems.
- Resources or extra capacity may need to be sought from international sources.

when large coastlines and multiple arrival points are involved *(321)*. Similar issues can occur in the context of terrestrial arrivals when borders are long with a large number of arrival points or isolated arrival points. Another area of difference was noted between those Member States that were primarily involved in reception and transit, such as Serbia, and those where refugees and migrants remained for longer periods of time, such as Greece, Italy, Malta or Turkey *(322)*. Longer-term health issues assume greater prominence in the latter group, while referral and continuity of care can be important in the former. Depending on the situation, initial medical assessment may be undertaken by police *(323)*, naval or military medical services rather than the civilian health sector.

Health information systems

Delivering high-quality and appropriate health care to those who need it requires accurate and relevant information on the health status and health needs of populations. Key challenges include the heterogeneity, accuracy and reproducibility of data *(324)*. Across Europe, there is limited information on health assessment and provision for newly arrived refugees and migrants and a considerable variation in terms of health assessment approaches and best practices *(303)*. Refugee and migrant health information poses additional challenges for health information systems as gathering and comparing data are made more complex by variations in definitions for migrant populations and by accessing this community *(325)*. Fig. 2.6

Fig. 2.6. Member States in the WHO European Region that collect systematic information on the health of refugee and migrant children



Source: WHO Regional Office for Europe, 2018 *(271)*.

indicates the Member States in the WHO European Region where systematic information is collected on the health of refugee and migrant children and Box 2.7 describes one health information system specifically targeting newly arrived refugees and migrants.

Refugees and asylum seekers commonly represent populations in need in the WHO European Region, but evidence about their health status is presently limited or unavailable in most Member States, which limits the understanding of refugee and migrant health in the Region. Several Member States regulate by law and structure the collection of data on health status, health screening and outbreak surveillance but such collection is often hampered by a lack of financial and/or human resources *(13)*.

In the EU only four Member States (Austria, Croatia, Germany and Portugal) had defined indicators to measure the integration of refugees and migrants in the field of health and health care at the end of 2017 *(326)*. Chapter 3 gives details of the results of a recent survey on health policies and data collection regarding displacement and migration carried out by the WHO Regional Office for Europe. It has been suggested that national health information systems, in addition to public health surveillance systems, should collect standardized and disaggregated data for all refugees and migrants. Consensus on the nature and type of the data fields is required and the information will need to adequately comply with data protection, privacy and confidentiality measures *(327)*. Some countries do already assess migration status in their mortality statistics *(327)*.

Assessment of reliable data and using common and comparable definitions when collecting these data will improve understanding of the use of health services by refugees and migrants, identify needs and areas for interventions, and generate evidence-informed policy; however, further research is needed to support this *(327)*. A recently developed tool, the Health Information Assessment Tool on Asylum Seekers, was used to assess health information systems in Germany and the Netherlands with regards to the health status of asylum seekers as well as their access to health care. Serious limitations were found in regard to the assessment of migrant health data *(328)*.

Box 2.7. Red Cross health information system used for the migrant population in Greece

The Health Information System 2.0 was used by the Spanish Red Cross for the Greece Population Movement Intervention. The system allows the online collection of data from Red Cross medical centres through an Android open source application (Open Data Kit), which are then stored and managed for use through visual online user-friendly interfaces. Tablets for accessing this system are specifically provided and configured for this use.

Data are collected on visits/consultations and their characteristics for all staff in every speciality; the number attending are also logged with their health profile. This facilitates follow-up for each patient within the treatments provided only by Red Cross health services. The collected data are stored and checked to avoid any human errors during the collection process. Any issues are shared with the medical staff in the field for resolution.

Health Information System 2.0 uses two different online dashboards. The health report dashboard shows statistical information about the general situation in sites for a specific period of time; both date and site can be used as filters to access the desired information for reporting, monitoring or evaluation purposes. The second dashboard for patient follow-up is designed only for the professional use of medical staff to access the medical record of each patient.

Source: Spanish Red Cross.

Gaps in coverage and discrepancies

Key points: gaps in coverage and discrepancies

- Information on how to use services is often difficult to access by refugees and migrants, particularly if there are language and cultural barriers.
- Lack of human and financial resources limits the availability of screening services and vulnerability assessments for migrants.
- Discrimination and difficulty in integrating also act as barriers to accessing care.
- Fear of migration authorities, lack of awareness of rights and poor socioeconomic status affect migrants with irregular status.

Access to health care services varies greatly across the WHO European Region and within the national boundaries of Member States. Barriers faced by refugees and migrants in accessing health care services include uncertainties about how to register in health systems, a shortage of interpreters and cultural mediators, a lack of resources and a lack of legal support services *(13)*. In particular, a lack of resources for provision on arrival of refugees and migrants and in migrant detention centres further limits screening services and vulnerability assessments. Services in the WHO European Region have mostly evolved reactively to needs or emergencies rather than proactively, often utilizing systems set up for other situations. Nevertheless, a more proactive approach, as in prevention programmes, would be beneficial and contribute significantly to health equity *(329)*.

Some of the gaps in coverage have already been addressed in the section on entitlements to care. Here other barriers to accessing health care will be further addressed.

Accessibility of health care services

General barriers

Refugees and migrants most frequently cite financial barriers as a difficulty in accessing health care and so putting up health care barriers such as access charges (even if some diseases such as TB are exempt from these) may delay their attempts to seek health care through fear of incurring charges, thus stressing the importance of universal health coverage *(330)*. Other cited barriers are administrative problems, lack of knowledge or understanding of the health care system and of their rights, and language barriers *(61,294)*.

Access to health care services varies greatly across the WHO European Region and within the national boundaries of Member States *(331)*. While some Member States may have national health strategies, these strategies often do not make any reference to refugee and migrant health or accessibility to health care for the refugee and migrant population *(326)*. Generally, when state systems are not accessible or are ineffective, there is a high demand on NGO resources to bridge the shortfall and often increased pressure on accident and emergency departments *(13)*.

Many countries in the Region cite a lack of resources and shortage of interpreters and cultural mediators at hospitals, clinics and reception centres as reasons for the barriers in accessing health care services *(306,332–336)*. In some Member States, such as Italy and Spain, lack of legal support services also acts as a barrier *(306,335)*.

Lack of human and financial resources has been identified as a factor limiting access to screening services and vulnerability assessments upon the arrival of migrants *(332)*, and also for access to vaccinations, health promotion, specialized services for chronic conditions and those with disabilities, mental health services and dental services *(332)*. Médecins Sans Frontières has reported a lack of resources, a lack of medical screening and medical consultations, and gaps in vulnerability identification as barriers to accessing health care for

migrants arriving in Italy *(337)*. Improving access to health care coverage for refugee and migrant populations can be achieved through supporting patients with registration and involving interpreters in the process of making appointments and attending services *(13)*.

Discrimination can also be a barrier to accessing care. Research among refugees in Germany suggested that discrimination often caused mental health problems, which subsequently led to issues with physical health *(338)*. A meta-analysis of 36 studies identified many physical health outcomes of perceived discrimination, such as chronic conditions (cardiovascular diseases and diabetes) and general illness indicators such as pain and headaches *(339)*. Linked with discrimination is the issue of integration of the refugee or migrant into the new host community. Refugees and migrants living in Member States of the Region with less favourable integration policies (exclusionist, assimilationist) have reported poorer health outcomes (all-cause mortality, depressive symptoms and self-reported health status) *(340–342)*.

Barriers related to migrant status

Evidence of the utilization of health care services by irregular migrants suggests that many are unfamiliar with their entitlements (where they exist) and face barriers in utilizing these health care entitlements *(343)*. Other significant barriers faced by irregular migrants in the WHO European Region are the risk of being reported to immigration authorities, lack of awareness of rights and poor socioeconomic status *(344)*. In Spain, women with an irregular migrant status were unwilling to access health services for issues related to the stress of migration through fear of the police, deportation or the financial cost of treatment *(345)*. A combination of structural/political, organizational and individual factors connected with the migrant women's living, socioeconomic and cultural conditions were directly related to limited use of preventive, curative and rehabilitative health and social services *(345)*. Sex workers face specific health risks and also barriers to accessing health care services through issues such as lack of health insurance and taking part in a criminal activity *(163,346)*.

While many refugees and asylum seekers may have the right under national law to access available health care, this does not guarantee that they will be willing or able to *(13)*. Often administrative procedures can create barriers in accessibility, such as requirements for documentation or discretionary decisions *(262)*. Social insurance-based systems require complex registration, making access to services even more difficult than with tax-funded systems *(13)*.

Differences have been observed in the provision of medical services within the Region, such as between reception centres within Sicily and Greece, where centre managers play an influential role in the dissemination of pertinent information. Given these significant differences, the UNHCR criteria for grading health services in reception centres does not accurately represent the barriers to accessing health services that refugees face, even if these services are provided on site *(313)*. Additionally, data regarding migrants in Israel suggested that barriers to health care include lack of clear or consistent legislation, the threat of deportation, discrimination and the inability to obtain work permits, resulting in poverty and harsh living and working conditions *(347)*.

Regardless of the actual prevalence of mental disorders in refugees and migrants, in countries with a high number of migrants there will be a significant number with mental disorders. Outcomes of these disorders are largely influenced by the degree of social integration but many migrants are likely to require mental health care. However, there is generally a lack of mental health services in the Region. There is no routine documentation of mental health care use or outcomes for migrants in vulnerable situations and generally there is a lack of culturally appropriate human and financial resources and mental health services for asylum seekers. In 2016, only 18 European countries funded staff training and health education on cultural awareness in mental health care. In Italy, assessment of mental health problems in arrival facilities was inadequate or absent, and the transfer of patients to medical facilities was slow *(14,337)*. For labour migrants in Europe, navigating the available health care services is often challenging. Major barriers to accessibility include lack of information and familiarity with laws and rights regarding health care, occupational health and safety regulations, restrictions to direct access and costs *(159)*.

Migration detention

International guidelines state that detention of migrants should only be used as a last resort *(348–351)*. In spite of these legal standards and evidence of the short- and long-term harms of detention, migrant detention is widely practised across the WHO European Region *(352)* for reasons such as unclear identity, health and security assessments, and prevention of absconding and/or non-cooperation with authorities in relation to identity verification or deportation processes *(348,349)*.

The majority of detainees in the EU are migrants who have applied for international protection or those who have exhausted the legal process of seeking protection and are waiting to be deported from a host country *(353)*. Data are sparse and it is difficult to obtain an actual overview of the scale and practice of migration detention in Europe *(354)*.

Studies across the Region from 2009 to 2016 have reported limited availability of health services and lack of access to health care in detention facilities *(355–361)*. Most frequently reported barriers to health care in detention are lack of interpretation services, lack of access to information and limited human resources *(355,356,362,363)*. Detained migrants usually exhibit a disease profile similar to that of the country's refugee and migrant population but detention can aggravate or initiate ill health *(344,359,363–369)*, particularly mental ill health *(359,363,364,368, 370–376)*. Detention can be a particular issue for vulnerable unaccompanied minors *(348)*.

Children (particularly if separated from their families *(349,361,373))*, torture victims *(374)* and pregnant women *(377,378)* are vulnerable groups in detention, but specific procedures and/or facilities are not always available for them *(364,378)*. Numerous international and regional human rights mechanisms have repeatedly insisted that children must not be detained for migration-related reasons and in most countries detention of children is against policy. However, in practice, minors are often detained *(354)*, sometimes simply because of lack of alternatives. Evidence clearly indicates that the experience of detention, even for a brief period, has a detrimental effect on the mental and physical health of children *(356,367,368,373)*. An additional health issue associated with the detention process occurs when migrants detained prior to deportation have chronic health conditions *(367)*. During the period awaiting a final decision on deportation, they may have had access to care and services that are not easily available after their return *(379)*. Appropriate and necessary medical services, including psychological and mental health services, should be provided. Alternatives to the detention of migrants may reduce and mitigate their downstream health needs *(380)*.

Culturally sensitive health systems

One important method to ensure the provision of adequate health care is to acknowledge the strength of patient-centred care *(381)*. Across the WHO European Region, Member States are adopting more culturally sensitive health care systems to avoid discriminating against those whose needs differ from the majority, such as refugees and migrants *(382)*. The importance of intercultural competence and cultural sensitivity in health care systems is being increasingly recognized as integral to the provision of equitable and adequate health care *(383)*.

The United Kingdom has attempted to move towards intercultural competence and cultural sensitivity in health care by embedding diversity sensitivity at a policy level. The National Health Service has attempted to create a "personal, fair and diverse" service by making it a legally enforceable general duty to eliminate unlawful racial discrimination, promote equality of opportunity and ensure racial equality in employment *(384,385)*.

Culturally sensitive health care has also been implemented across the Region through the training of health care professionals to carry out their activities in interculturally competent and culturally sensitive ways (Box 2.8).

In several Member States, intercultural mediators act as a bridge between patients and health care

Box 2.8. Migrant and Ethnic Minority Training Packages

From 2013 to 2016, the European Commission supported a consortium of four organizations to review, develop, test and evaluate training on migrant and ethnic minority health for frontline health professionals in primary care settings. Pilot training packages were delivered over three consecutive days to a total of 208 participants in Denmark, Italy, Poland, Romania, Slovakia and Spain. Evaluation of the project revealed differences in experience across the study sites. Overall, the training worked well when targeted at a range of different health professionals together. In Italy, for example, where the public health system is decentralized, the opportunity to learn from a diverse array of trainees was welcomed by participants. In Denmark, however, some of those involved found the course content too basic and felt that different levels of training would be more appropriate. Because health professionals across the WHO European Region have very different educational profiles and experiences, adapting to local and professional contexts is key to the effective uptake and impact of training.

Source: European Commission, 2016 *(386)*.

professionals. Intercultural mediators help to facilitate effective, respectful and culturally aware dialogue between health care providers and users, support patients in navigating the health system and ensure that the patient receives appropriate follow-up services within the health system and with other key welfare, social and legal services *(383)*. In Malmö, Sweden, for example, health advisors with a refugee or migrant background perform a similar role to intercultural mediators. They are refugees and migrants who had a medical background prior to their arrival in Sweden and so are well situated to engage refugee and migrants in discussions about nutrition and exercise choices and to support them in navigating the provisions available concerning sexual and reproductive health. In Rome, Italy, a public register of intercultural mediators was set up in 2006 *(387)*. Mediators who want to work inside public offices such as social services, hospitals and schools must register, and strict criteria relating to language skills and competence have to be fulfilled for inclusion on the register. The register is updated annually to check mediator competence and to propose training courses to update knowledge in a way that is responsive to current needs in Rome and the Lazio Region. In 2015, there were 520 enrolled mediators from 80 different countries.

Migrant participation in health care services and decision-making is another method that has been utilized by Member States to promote intercultural competence and diversity sensitivity *(383)*. The Dutch Intercultural Centre for Mental Health Expertise set up a user committee of Cape Verdean migrants to disseminate information about available mental health care and to enable dialogue between users, providers and health authorities *(388)*.

Participatory photography sessions used images created by members of a Pakistani community in Denmark to initiate discussion and action around a common experience or issue *(389)*. These images stimulated discussions between migrants and health care workers, revealing that Pakistanis in Denmark did not consume unhealthy foodstuffs out of ignorance but rather as a result of the interaction between attempts to balance recommended healthy food practices with other cultural practices and the behaviours and practicalities of life and work schedules *(389)*.

There is, therefore, some evidence of Member States of the Region attempting to bring together information on, and experiences of, intercultural competence and diversity sensitivity, and to introduce tools and resources that may be applied at various stages of the health care policy and provision process. Member States are realizing and responding to the fact that intercultural competence and diversity sensitivity are both necessary and possible in all aspects of health care, from health care policy and physician training through to the use of participatory methods that provide refugees and migrants with the opportunity to receive adequate patient-centred care.

Conclusions

Promoting the health status of refugees and migrants has been prioritized by WHO through the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(272)* and through two World Health Assembly resolutions, WHA61.17 *(390)* and WHA70.15 *(391)*, and upcoming global action plans *(392,393)*. All call upon Member States to promote the health of refugees and migrants through refugee- and migrant-sensitive health policies and health care, equitable access to health care, evidence-informed practice and refugee and migrant health information systems.

A key aspect to promoting the health of any population is understanding the burden of disease and health risks faced. For refugees and migrants, communicable diseases have received the most attention but there is growing awareness that there is a broad range of issues, such as NCDs, maternal and child health and occupational health, also requiring targeted policy and culturally sensitive practice.

Overall gaps

The diversity of the refugees and migrant population in the WHO European Region makes it difficult to obtain comparable data and draw conclusions about the population as a whole. While refugees and migrants in the Region appear to have similar or lower all-cause mortality rates as the host populations, this does not mean that their overall health is better than the host population *(394–396)*. There are many issues that make it difficult to generalize from research findings on refugee and migrant health in the Region to the entire population, including the use of too generic, very specific or non-comparable definitions of the migrant population observed; issues such as country of origin, ethnicity and country of destination; and whether or not the population considered is of migrants or includes their children born in the host country. In addition, studies have often focused on one specific disease, such as ischaemic heart disease or HIV infection.

Gender is considered one of the key social determinants of health and has important implications for health policy and for equitable health care for all *(397)*. Disaggregating health research by sex can lead to more informative results; however, such data among refugee and migrant population are limited.

Age is also a particular concern in that both children and the elderly have health issues related to their age group. Given that children make up a significant proportion of migrants in WHO European Region and that health care targeting this group will support promotion of health across the entire life-course, it is important to provide age-disaggregated data when conducting research regarding the health of the refugee and migrant population. One of the key issues facing the Region is population ageing and ensuring that people can stay healthy and active as they age. While there are similar disease patterns across refugee and migrant populations and majority host populations (e.g. increasing levels of NCDs), the health of elderly refugees and migrants may also be influenced by socioeconomic pressures and the long-term effects of traumatic experiences and exposures to risk factors during their displacement and migratory experience.

Most evidence presented in this chapter suggests that a combination of multiple factors, including displacement and migration, influenced the health status of refugees and migrants, with some studies identifying lower socioeconomic status and social exclusion as the reasons for disparities seen between migrant and non-migrant populations. Access to social and health services varied among the Member States of the Region, typically with legal status being one important factor. Accessibility was also hampered by language barriers and lack of information on entitlements among both service providers and service users. Discrimination was only briefly addressed in the studies reported here, with most information linked to mental health and barriers to accessing health care services; only rarely was it considered as a factor for physical disease care. However, discrimination can affect both mental and physical health. Linked to this is the issue of integration of the refugee and migrant into the new host community. The studies in this report indicate that refugees and migrants living in countries with less favourable integration policies report poorer health outcomes.

Chapter 3 will address some of the policies and programmes that have been implemented throughout the Region to promote the integration of migrant health since the publication of the 2016 Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region.

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CHAPTER 3

Towards a refugee and migrant-friendly health system and universal health care in the WHO European Region

Refugee and migrant health and Health 2020

Reflecting World Health Assembly resolution WHA61.17 in 2008 *(1)* and the subsequent global consultation in Madrid in 2010 *(2)*, the WHO Regional Office for Europe engaged with Member States, partner organizations and other stakeholders in advancing and implementing identified migration health strategies and priorities. Important aspects of this work included both support to integrate the health needs of refugees and migrants into national health strategies, policies and programmes of Member States and assistance in scaling up preparedness and response in relation to the complex crisis and mixed flows of refugees and migrants from the Middle East and north Africa that emerged in 2011.

Critical to these activities was adoption of Health 2020, the European Region policy framework for the promotion of equitable health and well-being, by the 62nd session of the Regional Committee in 2012 *(3)* and other major regional policy frameworks aimed at facilitating and supporting universal, sustainable, high-quality, inclusive and equitable health systems in the Region. The framework has drawn particular attention to population movement and health, as well as issues of population vulnerability and human rights, and has provided a comprehensive foundation for public health work in the Region.

The basis of Health 2020 is the improvement of health for all, and the reduction of health inequalities through policies focused on four priority areas: investing in health through a life-course approach and empowering people; tackling the Region's major health challenges of communicable diseases and NCDs; strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; and creating resilient communities and supportive environments.

The policy framework is multisectoral, taking into consideration all determinants of health and emphasizing the need for participation by government, civil society and communities for preventive programmes, health promotion, better public health services and improved health system functioning.

In 2012, the WHO Regional Office for Europe launched the Public Health Aspects of Migration in Europe (PHAME) project specifically to assist Member States in planning and preparing responses to public health challenges associated with displacement and migration and in the protection of the health of refugees, migrants and host populations. This later evolved into the Migration and Health programme (see below).

Health aspects of large-scale movements of refugees and migrants to Europe

At the time when global and regional initiatives were under way to increase awareness of the health needs of refugees and migrants (see Chapter 1), a series of conflicts and accompanying geopolitical factors created profound changes in refugee and migrant numbers and movements in the Middle East and Mediterranean area. By 2015, unprecedented numbers of refugees and migrants were coming to Europe, many by dangerous maritime (and sometimes land) routes. At the time, the scope and volume of the arrivals threatened a humanitarian crisis and risked overstretching the capacities of some of the countries of transit and destination. In addition to the health effects and consequences of the often-perilous journeys to Europe, with over 14 000 recorded deaths from 2015 to the first six months of 2018 *(4)*, many of those arriving had complex health and social needs resulting from their exposure to violence, conflict, displacement and inhumane smuggling and trafficking schemes. They also had often been unable to access the routine health care they needed for a considerable period.

The influx of refugees and migrants into the WHO European Region occurred as a series of repeated waves encompassing tens to several hundreds of refugees and migrants, often simultaneously in different areas, and increasing significantly in frequency during the summer months of 2015. The increased frequency of arrivals of these mobile populations, the conditions in which they arrived and the number of people involved created challenges for the countries receiving them *(5)*.

The geographically large area affected and the multiple entry points posed particular challenges for reception and emergency management: coordination of different actors, including various institutional bodies belonging to different ministries; logistical complexity of the search-and-rescue process; identification of refugees and migrants and initiating asylum petitions; protection of vulnerable individuals; and arrangement of temporary settlement. Although Europe has historically hosted a significant number of refugees and migrants, the recent unplanned and often tragic arrival of large numbers of refugees and migrants divided European society and created a marked politicization of the debate around displacement and migration that put into question the foundations of solidarity, the refugee protection regime and the free movement of people agreement.

The crisis often required the identification and scaling up of existing basic services to meet the essential needs of the refugees and migrants through varying gradients of local preparedness, emergency management capability and effective multisectoral coordination. The experience clearly indicated the requirement for longer-term programmes to address refugee and migrant health needs plus the specific aspects of public health associated with migration and displacement crises, including:

- defining and assessing standards for living conditions, health care provision and epidemiological surveillance in all reception centres;
- defining and implementing national multisectoral contingency plans in anticipation of influxes of refugees and migrants, including a clear chain of command, coordination and control;
- setting up and strengthening existing institutional capacity;
- defining and implementing clear refugee and migrant immunization and screening policies;
- harmonizing health data collection systems and the use of personal health records;
- mobilizing human health resources and funding;
- developing national curricula for cultural mediators; and
- sharing good practice and developing public sector managers' capacity in dealing with migration and displacement issues.

Issues can be identified in two broad areas: priority conditions requiring attention at the arrival phase and then the longer-term challenges for both refugee and migrant health and the public health system.

Provision of health care at the arrival phase

The immediate health and medical needs of arriving refugees and migrants encompass those present before their journey began and those resulting from the migratory and displacement processes. Both create situations where arriving refugees and migrants need urgent care and attention.

Refugees and migrants with pre-existing or previously unknown conditions (e.g. cardiovascular diseases, diabetes, pregnancy or malignancies) might not have had access to medical attention or treatment before or during their travel and arrive needing treatment *(6)*. Apart from complications arising from lack of care, common infections acquired during the journey and lack of nutrition can worsen the condition. This necessitates identification of the problem and possibly intensive care on arrival.

In addition, the journey itself, which often extends for a considerable period, can expose refugees and migrants to violence, trauma and injuries; abuses; confinement in overcrowded settings deprived of hygiene and proper sanitation; exposure to the elements and transportation-associated risks; and lack of adequate nutrition. Disorders more commonly seen in refugees and migrants arriving in Mediterranean locations were dermatological conditions (18%), physical injuries (13%), dehydration (11%), gastrointestinal conditions (7%) and respiratory conditions (3%) *(7)*.

Priority conditions identified as requiring attention at the arrival phase *(8)* included:

- acute infections (e.g. gastrointestinal, urinary tract, eye or respiratory);
- infectious diseases of public health importance (e.g. TB);
- vaccine-preventable diseases;
- dermatological conditions;
- conditions during pregnancy;
- consequences of sexual and physical violence; and
- mental disorders, including PTSD and depression.

International guidelines recommending syndromic surveillance for diseases of public health importance in refugee and migrant centres were prepared for Europe *(9)*. Member States confronted with large refugee and migrant flows quickly developed national guidelines and instructions for managing the evolving health conditions at major reception locations. Systematic generalized medical screening for refugees, migrants and asylum seekers arriving during the crisis was considered and undertaken in some locations. Subsequent analyses helped to determine which screening procedures were most effective. A study in Germany noted the utility of screening for active TB but also that routine screening for other disorders was often of low yield and costly *(10)*. Targeted risk-based medical assessments proved to be more effective *(11)*.

Longer-term challenges for both refugee and migrant health and the public health system

Some longer-term health challenges could also be identified *(12)*:

- availability of specialized care in situations where new arrivals remain in reception centres of limited health capacity and at a distance to or inaccessible for mainstream services;
- provision of continuity of care for refugees and migrants who are initially assessed on arrival but then move to another destination;
- cultural and linguistic barriers impeding access to health care; and
- creation of routine settings, especially in community care services, to integrate the health needs of refugees and migrants.

Similar issues can occur if refugees and migrants are transferred to temporary holding facilities or detention centres *(13)*. Depending on location and facility capacity, access to some levels of medical care may be limited or unavailable *(14)*. Medical care may be interrupted or end as individuals are moved or placed at a distance from the location where they initially interacted with the health sector *(15)*. Records of treatment and immunization can become lost. In some instances, the use of portable personal health records to ensure follow-up and continuity of care has been considered and appraised *(16)*.

A commonly encountered problem relates to the integration of general medical, psychosocial and protection services. Vulnerable or traumatized individuals (e.g. victims of trafficking and gender-based violence, victims of torture and trauma, and unaccompanied or orphaned minors) often have both physical and mental health disorders. Uncertainty or insecurity related to the outcome of asylum claims, housing, family separation, employment prospects and future expectations all impact the health of new arrivals regardless of prior traumatization. Multiple, complex problems frequently generate complex health and social needs. Addressing those needs requires integrated and, if possible, seamless care provided through coordinated health, social and cultural mediation services *(17,18)*.

Stepping up action on refugee and migrant health in the WHO European Region: towards a common strategy and action plan

A High-level Meeting on Refugee and Migrant Health in the WHO European Region was held in 2015 *(19)*, in which Member States agreed on the need for "a common framework for collaborative action on refugee and migrant health, acting in a spirit of solidarity and mutual assistance, to promote a common response, thereby avoiding uncoordinated single-country solutions". The meeting noted the following:

- health systems in the countries receiving refugees and migrants were well equipped and experienced in diagnosing and managing common infectious diseases and NCDs, and the arrival of refugees and migrants did not pose additional health security threats to host communities;
- immunization programmes, risk-based non-discriminatory screening and proper surveillance were recommended for both communicable diseases and NCDs;
- refugee and migrant communities and civil society should be involved in order to enhance the cultural, religious, linguistic and gender sensibilities of health services and to support the health workforce;

- sustainable models of health care financing to cover refugee and migrant health care needs had to be identified locally, regionally and globally, with an emphasis on human rights and non-discrimination;
- national and transnational data systems were required to ensure monitoring and continuity of health care for individuals; and
- the development of multisectoral responsiveness and its progressive strengthening and adaptation should be periodically assessed by national and governmental institutions and supported by WHO and other international partners.

It was recognized that responses were complex, resource intensive and challenging, particularly for countries experiencing economic crises and when local systems were not adequately prepared and supported; therefore, mutual support and sharing of expertise among Member States was advised. The resulting Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(20)*, the first of its kind across WHO regions, provided an opportunity to reconcile under common concepts and principles the immediate response needed for a large-scale, acute, crisis-driven situation, such as the rapid influx of refugees and migrants, and the strengthening of public health and health systems to provide an integration-oriented response to longer-term population changes with structural migration.

The Strategy and Action Plan outlined nine strategic areas relevant to refugee and migrant health in the Region (Fig. 3.1a). It also defined a series of five indicators relevant to both national health policies and the refugee and migrant health-related priority areas in order to support the regular monitoring of progress in the Action Plan's implementation (Fig. 3.1b). The results of a first survey examining these indicators in those 40 Member States of the WHO European Region that provided responses are given below.

Fig. 3.1. The Strategy and Action Plan for Refugee and Migrant Health outlines (a) nine strategic areas and (b) five indicators to monitor its implementation

(a)

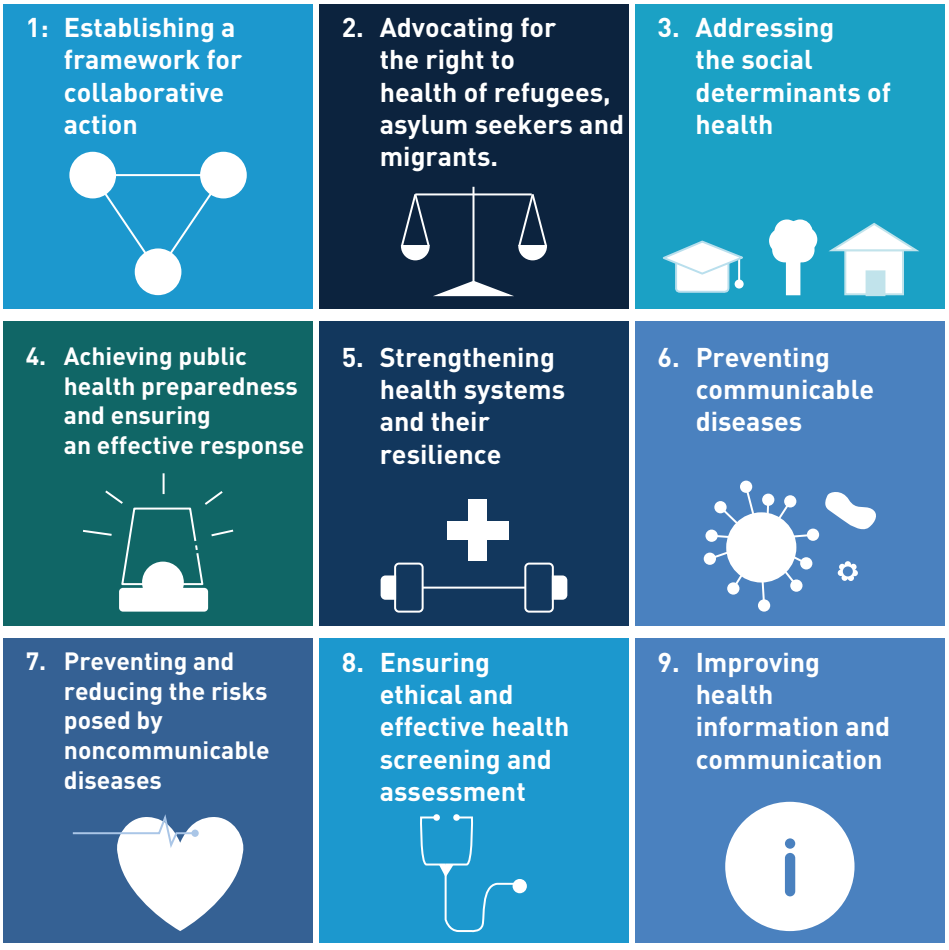


Fig. 3.1. (contd)

(b)

The WHO Regional Office for Europe's Migration and Health programme

The WHO Regional Office for Europe's Migration and Health programme (formerly called PHAME) is the first fully fledged WHO programme on migration. The programme provides support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. This includes promoting interregional and intercountry collaboration, improving data collection and sharing of practices, producing evidence and research reports, and providing networking platforms, dialogues and knowledge building. Among its initiatives is the establishment of a Migration Health Knowledge Hub in partnership with leading agencies and academia to build expertise and competence on the public health aspects of migration. As part of the work of the Knowledge Hub, the School on Refugee and Migrant Health held its second session in September 2018. The School was organized with the support of the Italian Ministry of Health and the Sicilian Regional Health Authority in collaboration with the IOM, the European Commission, the European Public Health Association and the Italian National Institute for Health, Migration and Poverty. The School, offered under the umbrella of the Knowledge Hub, aimed to improve participants' knowledge and understanding of the main health problems and needs of refugees and migrants and of the wider public health implications of large-scale displacement and migration. It also aimed to promote access to health services for refugees and migrants and in this way support health systems in the destination and transit countries that provide these services. This year the School hosted more than 80 participants from nearly 20 European countries as well as from Africa, North and South America, and east Asia. The five-day course included a combination of keynote lectures, plenary presentations and workshops, plus a field visit and a search-and-rescue simulation conducted by the Italian Coastguard. The School faculty included 50 speakers, including many academics, from all over the globe and from different institutions and international organizations.

Additionally, the Migration Health Knowledge Management Project, in collaboration of the European Commission, is developing technical guidance documents to address identified knowledge gaps across six priority issues in refugee and migrant health: child health, elderly health, health promotion, mental health, mother and newborn health, and NCDs.

One of the main tasks of the Migration and Health programme is to support Member States in the WHO

European Region in the implementation of the nine strategic areas in the Strategy and Action Plan in accordance with their national health priorities and policies. Progress in implementing the nine strategic areas was assessed through a survey conducted by the Regional Office and based on the five indicators (Fig. 3.1a). The survey will be conducted every two years until 2022.

First survey to assess implementation of the Strategy and Action Plan

The online survey questionnaire was based on the five indicators outlined in the Strategy and Action Plan and examined activities carried out by Member States during 2016 and 2017. Because various methods are used to define groups of migrants in different countries, which can impact on access to health care, the survey used the term refugees and migrants to refer to refugees and all groups of migrants, unless otherwise specified. Responses to the first survey were received from 40 of the 53 Member States.[1]

The survey results outlined here were presented to the 68th session of the WHO Regional Committee for Europe in September 2018 *(21)*. Examples of good practices presented here were collected as part of the online survey conducted by the WHO Regional Office for Europe and another survey conducted by the WHO headquarters *(22)*. The survey not only gathered results on current good practices but also explored Member States' intentions to include refugee and migrant health components in future policy. Fig. 3.2 summarizes the results from the survey.

Strategic areas covered

The most common area covered was strategic area 6 (preventing communicable diseases), which was a component of national plans in 23 Member States. This might be a result of the long-standing interest in the control and management of communicable diseases. The second and third most common elements were, respectively, strategic area 2 (advocating for the right to health), which was included by 22 Member States, and strategic area 9 (improving health information and communication), which was included by 19 Member States. Inclusion of these strategic areas indicated attention towards human rights-based approaches and the need for evidence in support of policy development in refugee and migrant health. However, reliable, comparable and nationally representative data on refugee and migrant health are still lacking, as indicated by the fact that only half of the responding Member States include refugee and migrant health-related variables in their national datasets.

Indicators covered

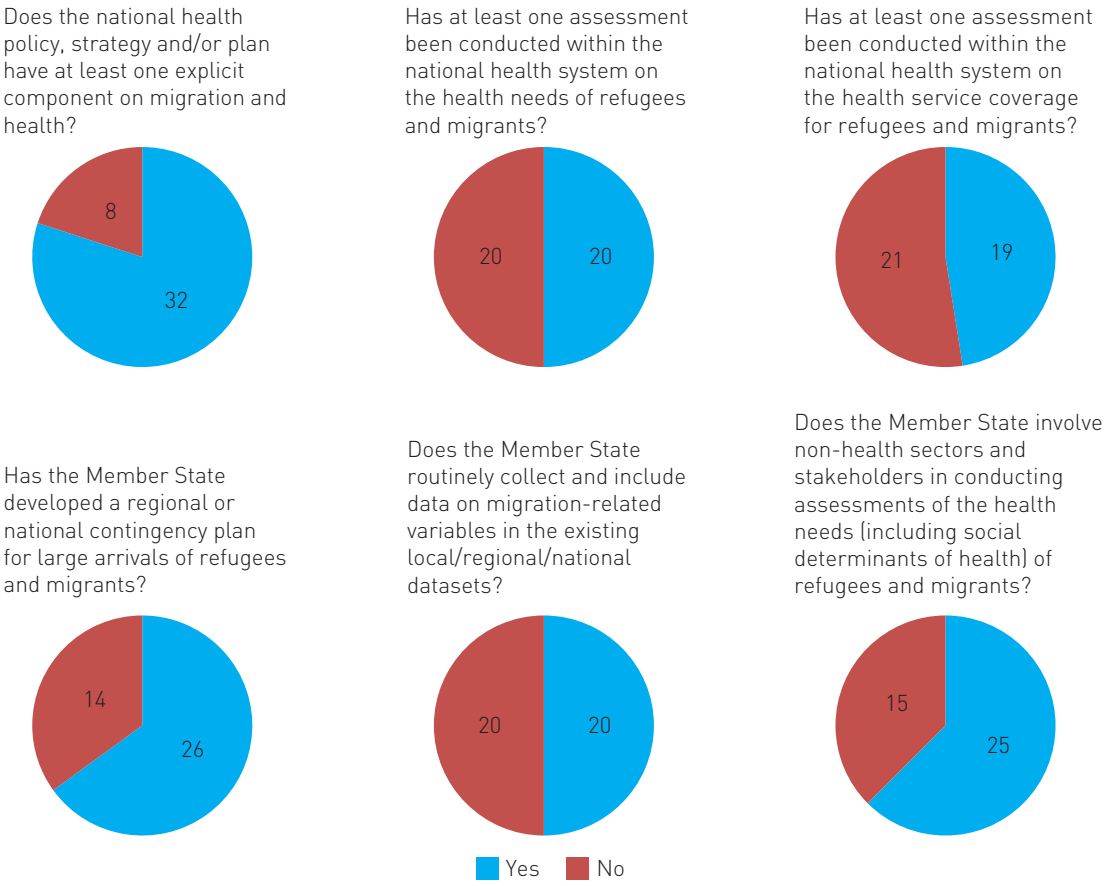
Indicator 1: inclusion of migration in national health policies, strategies or action plans

The inclusion of migration in national health policies, strategies or action plans is an important step towards realizing universal health coverage and creating refugee and migrant-sensitive health systems and services. At least one explicit component on migration and health in their national health policy, strategy and/or plan was reported by 32 Member States. Five of the eight Member States that did not include this component in their national policy indicated current plans to include migration and health in their policies and strategies in the near future.

A total of 32 Member States had an explicit component on migration and health in their policies, strategies and/or plans, often referring to specific categories: 23 Member States referred to refugees and asylum seekers and 16 Member States specifically recognized labour migrants and irregular migrants. Other Member States used specific categories in their policies and action plans: for example, Ireland included the Roma population; Kazakhstan included stateless individuals; Norway referred to all migrants residing in the country with a residence permit; and Turkey referred to migrants with temporary protection status. Case studies 3.1–3.3 describe policies in Andorra, Czechia and France.

1 Albania, Andorra, Armenia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Georgia, Greece, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Norway, Poland, Portugal, Romania, Russian Federation, San Marino, Serbia, Slovakia, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia and Turkey.

Fig. 3.2. Overview of the results from the 40 Member States that responded to the survey



Case study 3.1. First steps towards laws concerning refugees and migrants health in Andorra

Andorra is a good example of a country that has recently started the process of introducing aspects of refugee and migrant health into national policy. Different ministries, in coordination with other institutions and public and private entities, have been drafting a law to frame responses to the arrival of refugees. In 2017, the Andorran Council of Ministers approved the draft law on temporary and transitory protection for humanitarian reasons in response to the arrival of refugees from the Syrian conflict. The law was approved by Parliament on 21 March 2018: it contains a detailed description of steps to be followed when addressing the arrival and temporary protection of refugees. Medical assessments by the Immigration Medical Service, access to health care services and social care services are provided for the refugees.

Case study 3.2. Policies to promote quality health care for refugees and migrants in Czechia

Czechia is implementing the Policy for the Integration of Foreign Nationals, which aims to promote knowledge on migration issues and to eliminate language barriers between migrants and health care providers. A patient guide and communication cards in numerous languages have been provided by the Ministry of Health for migrants and health care providers. Additionally, dedicated centres offer free professional consulting for migrants on issues such as health care and health insurance. These centres also offer interpretation services and the option to have a cultural mediator accompanying migrant patients to health care providers. Refugees participating in the State Integration Programme for Beneficiaries of International Protection receive similar services.

Case study 3.3. Promoting equality in accessing health care in France

In France, the health system aims to be inclusive and accessible to refugee and migrant patients. As such, the same principles apply to legal residents as to French citizens. Asylum seekers are also covered by the universal free health insurance system (Couverture Universelle Maladie Protection Complémentaire). Low-income irregular migrants are covered by state medical aid (Aide Médicale d'Etat) with certain conditions and restrictions. However, there are exceptions for vulnerable and at-risk groups, such as people with infectious diseases and pregnant women, all of whom are granted a temporary permit to access health care. Anyone falling outside the system can access emergency services and care. Newcomers to France receive initial orientation to the health system, and information is provided in 23 languages. Practitioners are also being trained in guaranteeing equal quality services for refugee and migrant patients and the need to protect privacy.

Indicator 2: assessment of health needs of refugees and migrants

In order to develop evidence-informed policies and achieve adequate health coverage for refugees and migrants, national health systems must collect sufficient relevant data about the health characteristics and the specific needs of refugees and different migrant groups. National health systems must also have the capacity to respond to both the immediate and long-term health needs of these populations, especially those in vulnerable circumstances. An assessment of the health needs of residing refugees and migrants was made by 20 Member States (Case studies 3.4 and 3.5). Of the other 20, five had plans to do so. In terms of health service coverage for refugees and migrants, 19 Member States had such an assessment, with seven of the remaining 21 having plans to conduct one. The 20 Member States that conducted refugee and migrant health needs assessments primarily covered refugees, followed by asylum seekers. Irregular migrants, labour migrants and individuals with subsidiary protection or temporary protection status were also covered by the assessments in some countries.

Case study 3.4. Health monitoring of the refugee and migrant population in Switzerland

The National Programme Migration and Health 2014–2017 was introduced and directed by the Swiss Federal Office of Public Health in association with cantonal authorities and institutions. Core components of the project were ensuring equal access to health care regardless of nationality, ethnicity, language, culture and/or socioeconomic status; promoting health literacy among migrants; empowering migrant patients; encouraging active patient participation; facilitating integration; improving communication; training health professionals; and promoting research on vulnerable groups. As part of its research, the Federal Office commissioned monitoring to obtain a detailed dataset on the health of the refugee and migrant population in Switzerland. The key refugee and migrant population groups included in the survey were from Kosovo (in accordance with Security Council resolution 1244 (1999)), Portugal, Serbia, Somalia, Sri Lanka (Tamils) and Turkey. The main results were as follows:

- **health status:** migrants had comparatively good psychological and physical condition; younger migrants who had only just arrived in Switzerland were healthier than the resident population, while older migrants and those who had been in Switzerland for longer were less healthy;
- **health care utilization:** the proportion of people consulting a doctor (general practitioners and specialists) at least once per year was the same for the migrant groups assessed as for Swiss citizens but those individuals who had been granted international protection consulted a doctor more often; and
- **health behaviour:** female and male migrants consumed significantly less alcohol than Swiss citizens, but also ate less fruit and vegetables and did substantially less physical exercise.

Case study 3.5. Voluntary health screening for refugees and migrants to improve the quality of health care in Sweden

In Sweden, all applicants for international protection were screened by the country councils or regions in which they had settled on a voluntary basis. An interpreter could be involved in the process if necessary. The screening included questions about the patient's medical history, background and immunization status. A health dialogue was conducted to identify a person's psychosocial situation and present and past physical and mental health needs. The screening provided information on the type of health service that should be offered to refugees and different migrant groups.

Indicator 3: inclusion of a contingency plan for large arrivals

The potential for the sudden arrival of large numbers of refugees and migrants to the WHO European Region has created the necessity for contingency plans to improve the preparedness and ability of national health systems to respond to the public health needs of the refugee and migrant population. More than half of the responding Member States (26 of the 40) indicated that they had a regional or national contingency plan for such large arrivals of refugees and migrants. This might be a reflection of the awareness of the impact of recent large-scale refugee and migrant arrivals in the Region.

Of the 26 Member States that had plans in place, nine had tested the plan. Five of the 14 Member States without a contingency plan do intend to develop one. Few Member States have developed contingency plans specifically for large arrivals of refugees and migrants (Case studies 3.6 and 3.7), with most seeing this as part of their already existing national contingency/disaster response plan.

Case study 3.6. A pioneer contingency plan in Sicily, Italy

The Sicily Region in Italy was among the first to develop a contingency plan to respond to public health consequences of sudden high-volume arrivals of refugees and migrants *(23)*. The plan was developed in collaboration with the WHO Regional Office for Europe in the course of the large rescue operation Mare Nostrum in the Mediterranean Sea; it improved the efficiency of logistical and humanitarian operations through the systematic enhancement of procedures of public health. The plan provided in-depth information on the stressors and health risks and health risks refugees and migrants faced during the journey and on arrival, and provided medical triage at each stage of the process from initial contact with rescue services. Monitoring of health conditions in reception centres and a referral system were also established. The plan followed the results of an assessment conducted by the Regional Office in coordination with local and national authorities aimed at determining practices and gaps in view of high-volume arrivals of refugees and migrants and at identifying good practices for the subsequent development of a toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants *(24)*. The first contingency plan was developed and launched in 2015 *(23)*. In 2017, the plan was updated and relaunched *(25)*.

Case study 3.7. Preventing and controlling disease in Poland

The Office of Foreigners in Poland has public health protection procedures in place that assess the health status of migrants crossing Polish borders and seeking international protection. This is aimed primarily at diagnosing, isolating and providing immediate treatment for patients suffering from infectious diseases presenting an immediate epidemiological threat. Two reception centres carry out medical examination for migrants seeking international protection. The Office of Foreigners, with co-financing from the Swiss–Polish Cooperation Programme, has built a modern health services facility with specialized medical equipment dedicated to improving the effectiveness of public health protection at the eastern border of the EU. This has led to more support for refugee and migrant health programmes.

Indicator 4: inclusion of displacement and migration-related health in existing datasets

The inclusion of refugee and migrant health variables in existing national health datasets is necessary to create comparable and easily accessible health records for refugees, migrants and asylum seekers. The survey indicated that 20 of the 40 responding Member States routinely collected migration-relevant data as a part of some aspect of their national health information datasets. Among the 20 that did not collect this information, eight had plans to undertake such activities. However, methodology was not standardized, making comparisons difficult; for example, Belgium collected information on current nationality, country of birth and nationality at birth; Montenegro collected information on migratory status, country of origin, mode of travel and reason for migration; and Norway collected information on country of origin and reason for migration. Case study 3.8 is an example from Finland of a set of variables collected in relation to infectious diseases. Case study 3.9 outlines a centralized national database of refugee and migrant health issues that is updated weekly from regional health institutes.

Case study 3.8. Infectious disease information of relevance for refugee and migrant health collected by Finland

In Finland, the National Institute for Health and Welfare compiles the National Infectious Disease Register. Data collected are population data (year of immigration, country of birth, nationality and language) plus a completed questionnaire on communicable diseases, with the following items.

HIV and AIDS

Has the patient been diagnosed with HIV outside Finland (Yes/No/Unknown)?

Malaria

Patient's origin:

- Finnish (country of birth = Finland) and lives currently in Finland
- Finnish (country of birth = Finland) and lives currently in an area endemic for malaria for over a year
- migrant (country of birth = country endemic for malaria) and just arrived in Finland
- migrant (country of birth = country endemic for malaria) and lives currently in Finland and has visited a country endemic for malaria
- foreigner (country of birth = other than Finland) visiting Finland
- Other
- Unknown.

Exposure dates:

- date of entry to a malaria endemic country
- date of exit from a malaria endemic country
- duration of travel to a malaria endemic country (days/weeks/years).

TB

Has a child under seven years of age received a Bacillus Calmette-Guérin vaccine? (Yes/No/Unknown)

If Yes, in which country?

Case study 3.9. Serbia: health information system for refugee and migrant health

Serbia has a centralized health information system and works with institutes of public health based in 23 locations. All surveillance and preparedness activity for a particular region is coordinated through these institutes. A method has been developed for recording, collecting, processing and analysing data for refugees and migrants in Serbia. The data are entered into predefined forms and are submitted weekly to the regional institutes of public health, which enter these into the national database. Since 2015, Serbia has collected datasets on refugees and migrants, and a report collated once per week is shared with WHO and the Serbian Ministry of Health. The data are not currently disaggregated for specific conditions but cover broad concepts, such as mental illness and the rate of diagnosis within this category. The health information system is based on patient records that are noted in a logbook in each refugee and migrant centre (Serbia: rapid follow-up assessment on refugee and migrant health. WHO Regional Office for Europe, unpublished manuscript, 2018).

Indicator 5: intersectoral approaches for the assessment of refugee and migrant health needs

The involvement of all government actors, plus public health, non-state and non-health actors, is necessary to successfully establish a whole-of-government and whole-of-society approach for promoting refugee and migrant health in the WHO European Region. More than half of the 40 responding Member States (*n* = 25) used multisectoral action in evaluating and addressing the social determinants of health for refugees and migrants (Case studies 3.10 and 3.11).

Case study 3.10. Multistakeholder dialogue in Croatia

In Croatia, an action plan for the integration of people who have been granted international protection emphasized the collaboration between different stakeholders in providing adequate health care based on shared values, evidence and multisectoral policy dialogue. The action plan was approved by the Government of the Republic of Croatia, with key stakeholders being the Ministry of Health in collaboration with the Croatian Red Cross, Croatian Law Centre, Jesuit Refugee Service, Médecins du Monde and the IOM Country Office Croatia. Improving the general attitude among the public towards refugees and migrants is recognized as a paramount aspect of successful migrant health and integration into Croatian society.

Case study 3.11. Addressing the health of migrant workers in Tajikistan

The Ministry of Health and Social Protection (Ministry of Health) as well as the Ministry of Labour, Migration and Employment (Ministry of Labour) of Tajikistan established a collaboration with the IOM to develop policies and activities regarding the promotion of migrant health and migrants' right to health in Tajikistan with the aim of increasing the involvement of non-health-related government bodies in addressing the health needs of migrants. The Ministry of Labour became involved in the development of national policies related to migrant health, hosting multilevel training on HIV and TB prevention and in aiding the implementation of a project to promote HIV prevention among migrants and their families.

The Ministry of Labour and the Ministry of Health signed a joint work plan on TB prevention among migrants for 2017–2018. Activities have also been established by the Ministry of Labour to involve the Tajik diaspora in the Russian Federation in TB prevention and to promote the Minimum Package for Cross-border TB Control and Care among Migrants *(26)*.

The Ministry of Labour held meetings in 2017 involving the Ministry of Health, NGOs, the Tajik diaspora and the Ministry of Foreign Affairs to develop work plans for 2018 that will promote TB and HIV prevention among the migrant population through the Tajik Diaspora Network. This interagency collaboration illustrates the effectiveness of a multisectoral approach in creating national policies and programmes that promote migrant health.

Summary

This first survey of Member States' responses to the 2016 Strategy and Action Plan for the WHO European Region revealed progress in strategic planning and policy development to meet the health needs of refugees and migrants in the Region. A national focus on advocating for a rights-based and multisectoral approach to health was reported by more than half of the 40 responding Member States and was only slightly exceeded by attention to the issue of communicable diseases. There is a lack of reliable, comparable and nationally representative data on refugee and migrant health. One reason for this is that only 20 of the 40 Member States responding to the survey included migration-related health variables in their national datasets.

Conclusions

The impact of the large-scale arrivals of refugees and migrants that began in 2015 continues to be observed in the increased planning and policy attention directed towards refugees and migrants and the development of contingency planning. The Strategy and Action Plan for the WHO European Region is proving to be a driver of change in the Region to promote refugee and migrant health.

Access to health care for refugees and migrants varies across the WHO European Region in terms of legal entitlement and formal access regulations. Even where entitlement is established for formally resettled or registered refugees, and regulations permit access, further impediments exist in terms of the organization of health care, limitations in the expertise of the health workforce and limited support to overcome barriers to accessing care, as well as wider governance issues within migration. Health strategies that are broad enough and include all refugee and migrant cohorts will assist in the development of refugee and migrant-friendly health systems.

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CHAPTER 4

The way forward: a vision for health of refugees and migrants in the WHO European Region

What we have learned

Migration and human mobility are more than ever facts of life and structural aspects of the contemporary world. The WHO European Region hosts approximately 35% of the international migrant population. In today's globalized and interconnected world, migration is in all likelihood unstoppable and possibly even desirable in view of existing demographics and the economic and development benefits that migration mainly brings when well managed. The cumulative health needs of a population of this magnitude emphasize the public health importance of addressing refugee and migrant health for the realization of national and regional health goals, such as reducing inequalities in health coverage and the burden of communicable diseases and NCDs. The United Nations' 2030 Agenda for Sustainable Development *(1)* in 2015 recommended leaving no one behind, which necessitates fast-tracking actions for marginalized people and focusing on closing gaps for the common good.

The Member States of the WHO European Region are increasingly destinations for refugees and migrants. This trend is likely to continue and, therefore, scaling up action to address refugee and migrant health is an inevitable and far-sighted strategy for all Member States.

As pledged by World Health Assembly resolution WHA61.17, Health of Migrants, in 2008 *(2)* and in line with the core health principles expressed in the European health policy framework Health 2020 *(3)* and the operational priorities of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(4)*, it is the mission of national and international stakeholders, whether in governments, international organizations or civil society, to safeguard refugee and migrant health. This should extend throughout the displacement and migration process, regardless of the context in which the process takes place, in order to ensure that the right to health is always respected, excess mortality and morbidity is avoided, equity in accessing health services is realized as much as possible and negative health outcomes of migration are minimized. The Strategy and Action Plan outlines nine priority areas for implementation (see Chapter 3) and these form the background to the discussion below. The realization of the goals of preventing disease, morbidity and premature death has two main aspects:

- enhancing and monitoring access to preventive and curative health care for refugees and migrants; and
- creating societal conditions conducive for the health and well-being of refugees, migrants and communities.

Enhancing and monitoring refugees' and migrants' access to preventive and curative health care

Planning for refugee and migrant health services is best achieved by building on existing health system policies and infrastructure to ensure that refugees and migrants have access to existing routine health services and that parallel services are avoided, as far as possible. This also provides opportunities to strengthen and enhance policies and systems for routine services. However, health needs specific to refugees and migrants are not always sufficiently addressed by existing structures. This implies both making existing health systems more refugee and migrant sensitive through the adoption of specific evidence-informed policies and strategies and ensuring that health services are refugee and migrant friendly by overcoming the economic, logistic, linguistic and cultural barriers that refugees and migrants might encounter in accessing them. The realization of these key health system adjustments to achieve refugee and migrant health goals falls within the scope of health system strengthening and the constitutive "six blocks" of health systems: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance *(5)*.

Realizing equity in access to health care for refugees and migrants is ultimately a step towards the progressive achievement of universal health coverage. Each country might opt to set different priorities and solutions, depending on its history and relations, health system models, migration profiles, policies and legal frameworks. Nevertheless, it is sound public health practice to assess (using the universal health coverage's three dimensions of measurement, service availability and financial protection) which services

and of what quality are accessible to refugees and migrants, which costs are covered and, consequently, what critical gaps might exist. Chapter 1 outlined the wide diversity of situations, processes, legal statuses and resulting health needs involved in displacement and migration. Therefore, assessing issues of access to care and coverage should as much as possible be specific to refugees and key migrant profiles but also consider the cross-cutting aspects such as gender, age and the various factors determining vulnerabilities and resilience (e.g. individual health conditions and lifestyle, employment, education and level of integration). A minimum requirement for health needs assessment and coverage should be the differential consideration of refugees and all categories of migrant. Additionally, considering the transnational nature of human mobility and the health risks linked to social exclusion and limited access to care during displacement and migration, a public health approach should be maintained within the scope of health security, disease prevention and border disease control. A number of areas requiring specific attention are yet to become routine practices in many countries, for example the inclusion of refugees and migrants in pandemic preparedness plans and other contingencies; health risk reduction associated with mobility; surveillance for importable diseases within some at-risk communities; and cross-border measures for continuity of care. These so-called health security considerations should, however, not be used to stigmatize refugees and migrants or justify procedures such as extensive and systematic screening that is not commensurate with actual cross-border risks.

Creating societal conditions conducive for the health and well-being of refugees, migrants and communities

The social determinants of health will act along the displacement and migration continuum (i.e. at origin, transit, destination and return), and societal conditions are significant factors in the health and well-being of refugees, migrants and communities. Many of these factors lie outside the direct influence of the health sector. For example, health service provision to refugees and migrants does not always involve health authorities as it may be the responsibility and within the jurisdiction of authorities responsible for internal affairs. This may require redefining the role of health authorities in the coordination, supervision, provision and monitoring of health services. Planning and coordination of services for refugees and migrants provide opportunities for an integrated and intersectoral approach and can lead to improved cooperation among the responsible authorities. The development of favourable policies to address population movements, the cultural readiness to accept and manage diversity in societies, and multisectoral and multicountry cooperation have not kept pace with the growth in and fast-changing patterns of population movement. As a consequence, the conditions encountered during their journey, as well as the living, working and ageing conditions at their destination, can have negative health repercussions for many refugees and migrants. For example, avenues for regular, safe and planned migration remain scanty and are probably not in proportion to the existing employment opportunities in both low-wage and highly skilled posts in receiving countries. This encourages irregular migration flows and exploitative conditions in origin, transit and destination countries, accompanied by loss of lives along perilous journeys and severe physical and mental risks, including contracting diseases or the worsening of pre-existing medical conditions. These negative determinants have a particular impact on the vulnerabilities of women and children, which is of increasing significance given the growing proportion of women among international migrants (52% of international migrants in Europe are women) and the large proportion of children and youth (including unaccompanied minors). Additionally, the economic downturn in the WHO European Region and beyond, with reduction of investments in welfare and public services, and the sense of insecurity experienced by the widening impoverished section of the host population have fuelled xenophobia and anti-migrant sentiments in many countries.

Addressing the social determinants of health for refugees and migrants requires achieving a deep understanding of the various dynamics and processes involved in displacement and migration and proactively engaging at local, country, regional and global levels in relevant sectoral policy development and practices to curtail those factors with a negative health impact. This is particularly difficult for a health sector with a marked biomedical orientation and can only be achieved through partnership with other government sectors (particularly, labour, home and foreign affairs) as well as civil society, academia, refugee and migrant communities and key convening institutions and organizations. This whole-of-government and whole-of-society approach is at the centre of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, which identifies as

priority area 1 "establishing a framework for collaborative action" *(4)*. The implementation of the 2030 Agenda with its goals and targets (SDGs) offers excellent opportunities for collaboration and synergies, as will the future implementation of the global compacts for migration and for refugees, and the international mechanisms of reviewing and monitoring progress that will be put in place within the United Nations General Assembly and to which the health sector should actively participate *(6)*. Additionally, while much attention is given to certain aspects of displacement and migration, all regions and countries are both origins and destinations for refugees and migrants, and a coherent policy and management should, therefore, encompass both aspects. For example, equity in health coverage, access of refugees and migrants to health, and social and health protection should increasingly be a matter of dialogue and cooperation between countries of origin, transit and destination, addressing both immigration and emigration aspects. This is all the more significant for the WHO European Region, where the larger proportion of migration movement is within the Region.

Although finding work is the major reason for migration in the WHO European Region, violence, conflict, natural disasters and human rights abuses also displace individuals or groups of individuals. This type of movement is harsh, increasingly widespread, prolonged and unresolved. The issues that lead to it are still mainly addressed using contingency and temporary ill-suited measures that have significant shortcomings for the refugees, migrants and host populations. The resulting large-scale, unplanned, mixed flows of refugees and migrants have enriched a vast network of smugglers and traffickers, who constantly change routes and search for new arrival locations *(7)*. In some instances, this can find countries ill-prepared to respond to sudden arrivals as they that might not have assessed their preparedness or have developed ad hoc contingency plans. This can often contribute to creating in communities a sense of mistrust in the local and global capacity to manage displacement and migration and can fuel resentment, frustration and xenophobia. It is important, therefore, to consider sudden influxes as a structural feature of contemporary displacement and migration and to ensure that the national refugee and migrant health agenda includes specific provisions and core competencies in this respect.

In summary, the development of a comprehensive refugee and migrant health agenda needs to encompass aspects of both the long-term, structural and widespread presence of refugees and migrants within communities and the acute, sudden arrivals of mixed flows (people using the same routes and means of transport but for different reasons, often travelling in an irregular manner). The development or adaptation of policies and plans should preferably build on national population-based health strategies and be coherent with country-specific refugee and migrant profiles.

Advancing the implementation of the Strategy and Action Plan

The nine priority areas of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region agreed by Member States represent the operational synthesis of the policies summarized in the previous section. The results of the first WHO survey to monitor the implementation of the Strategy and Action Plan were presented in Chapter 3 and showed that a large number of Member States have engaged in scaling up action on refugee and migrant health at country level. The priorities indicated in the Strategy and Action Plan and the set of indicators selected represent an instrumental driver for change in the Region and beyond. The collaborative work undertaken in the Region under the leadership of the WHO Regional Office for Europe has contributed to promote the refugee and migrant health agenda more widely. The Seventieth World Health Assembly adopted a new resolution in 2017 (WHA70.15 *(8)*) and a WHO global action plan is being developed. In addition, various interregional platforms and, notably, the United Nations General Assembly have welcomed the case for reserving particular attention to health issues within global dialogues on displacement and migration including in the global compacts. This represents a meaningful example of realizing in practice the health in all policies vision and a contribution of the health sector in devising solutions to the complex and urgent challenges posed by displacement and migration today.

However, much remains to be achieved from local up to global levels before refugee and migrant health can be considered an agenda upheld within health

policies and the strategies and plans of the 53 Member States of the WHO European Region. A few key elements emerging from the first survey of the implementation of the Strategy and Action Plan and review of evidence are outlined below for consideration and future evaluation.

Strengthening governance

At both national levels and at local decentralized levels of the health system, it is important to enhance stewardship for the implementation of the Strategy and Action Plan. This entails identifying and mandating designated officials, services or departments to lead and ensure accountability and consolidation of achievements during the scaling-up phases. Lack of a defined health sector stewardship causes fragmentation and partial accountability. Considering the important work across sectors inherent to the refugee and migrant health agenda, and the complexity and sensitivity surrounding it, a high-ranking and resourced stewardship is needed, capable and equipped to devise the meaningful health diplomacy the role requires. Such a focal entity should be able to link acute responses to arrival and longer-term plans, and to ensure the establishment of formal and informal system-wide networks of partnership, relations and multisectoral coordination to overcome fragmentation and duplication of efforts. This should also facilitate a more systematic interfacing of national experiences and supranational examples and processes.

Strengthening evidence, evaluating coverage, assessing needs and effective communication

Migrant is a term that lends itself to varied interpretations and divisions into subtypes (see Chapter 1). The various categories might be linked to very diverse health needs and outcomes, depending on a plethora of individual and process-related factors. Many of these factors have been discussed in this report. Effective interventions, whether policy or programme related, intended to enhance refugee and migrant health indicators need as much as possible to be targeted and based on strong evidence. This evidence also needs to be communicated to the refugee, migrant and host communities to counter xenophobia and promote integration. Additionally, each country will have its own specific migration profile with its associated factors and dynamics (e.g. size and scope, such as labour migration or smuggling). Therefore, the development of a national refugee and migrant health policy agenda should be supported and validated by research and evidence and by a consultative process in partnership with reputable institutions. An assessment of health coverage should use the three dimensions of universal health coverage adopted by WHO: the refugees and various categories of migrants covered by health services, the nature and quality of services accessible to them, and financial coverage (e.g. contingency funding, budget allocation or pre-paid insurance schemes). Different migrant groupings might have very different coverage related to their status, national laws and the actors involved with the response to migration. The WHO toolkit for assessing health system capacity to manage large influxes of refugees and migrants offers a common template to enhance the evidence base for planning *(9)*, and the experience of Member States encourages its wide use.

Strengthening policy

There are two aspects to consider in relation to policies in refugee and migrant health: policies within the health sector to ensure equity and health coverage and policies in other sectors that might have an impact on health. The first concerns the explicit adoption or application of policies that specifically ensure equity and health coverage for refugees and various categories of migrants. A complementary approach to this mainstream strategy is the inclusion of an explicit reference to refugees and migrants within general population-based or disease-specific health policies. While many Member States have indicated that they have policy provisions for the health of refugees and migrants within their country's health or social policies (see Chapter 3), in some instances these provisions do not extend to all categories of migrants present in the country. This might create a vacuum that, by default, can have public health repercussions. A marked example is the situation of irregular migrants, who might only have access to emergency care or might opt to use substandard or inadequate forms of treatment that do not draw attention to themselves. Even where different gradients of coverage exist, policy enhancement might be required to ensure that all refugees and migrants are accounted for, regardless of how they are defined. Informed assessments of health outcomes would allow progressive policy adaptation towards universalism.

The second aspect refers to ensuring that policies in other non-health sectors do not lead to adverse health outcomes for refugees and migrants. This complex endeavour is better achieved when the health sector provides stewardship, promotes the observance of fundamental health principles and engages in constructive multisectoral dialogues, not only domestically but also regionally and globally. Global policy instruments and multilateral agreements can be instrumental in driving more stringent domestic policy coherence. A major current challenge is represented by xenophobia, often explicit racism, and sovereignism. This challenge risks setting back hard-achieved progress towards realizing equity and inclusive health systems that pursue only the best public health interest of all.

Strengthening grassroot participation and partnership

Health sector policy-makers involved in migration health need to adopt a participatory approach by ensuring grassroot presence and partnership and active participation by local authorities; community health providers; various sectoral parties, including the labour sector and civil society; and refugees and migrants themselves. This is to ensure that effective solutions are achieved locally through the building of trust and dialogue and that those solutions are translated into policy adjustments and the sharing of good practices. Solutions also need to be achieved at regional and global levels. The health of refugees and migrants cannot be addressed by country of origin, transit or destination alone. Efforts to safeguard and promote the health of refugees and migrants have to take place across the places of origin, transit and destination.

Many of the challenges faced in refugee and migrant health are relatively new or not yet encompassed within existing tools and strategies. Additionally, social and technological innovations, particularly in terms of communication, cultural mediation and social mobilization, are important and being progressively explored and developed at ground level.

Strengthening health financing and human resources

Large population movements can mean that swift recruitment of human resources is required, including doctors, nurses, midwives, dentists, psychologists, psychotherapists, nutritionists and other health professionals. Ad hoc initiatives to deploy staff swiftly by using voluntary contractual or commissioning arrangements or by reducing administrative barriers to deploy additional staff in the existing system are a possibility. Such ad hoc recruitment may be beneficial for addressing the health and humanitarian needs of refugees and migrants, but they need to be weighed against the sustainability and quality of service provision in the longer term. Intercultural mediation is an important tool to facilitate people-centred care in service delivery in a multicultural context *(10)*. It requires specific attention to training health professionals, from both the refugee and migrant population and the host population, in routine settings *(11)*. A longer-term strategy to deploy and train health services staff on the standard practices in the existing system is advisable. Countries need to be prepared to mobilize additional funding for any situation in which health services suddenly experience increased needs. Large population movements pose specific challenges and opportunities to health systems. As the context and funding mechanisms for health services differ from country to country, approaches in mobilizing funding must be understood for each country. Countries with more centralized approaches have tended to find more unified responses to mobilize additional public funding, although this also depended on the scale of flow. Countries with more decentralized approaches have tended to experience more variety in local responses and innovations, particularly related to mobilizing voluntary funding from private sources. Public supervision and public co-funding for services provided under private arrangements are essential to ensure alignment of objectives and ensure sustainability of funding.

Strengthening national data collection systems

Delivering high-quality health care to those who need it most is one of the basic components of global health. To complete this task, accurate and relevant health information is required to support evidence-informed policy planning and development. In the same way, any empirical approaches to address refugee and migrant health issues should be founded on accurate and reliable information, particularly given the complexity and diversity of modern displacement and migration. As Chapter 2 indicated, at present there are almost no regionwide indicators, and so no data to compare and get an overview of refugee

and migrant health in the WHO European Region. The situation in other Regions is similar. The first implementation survey for the Strategy and Action Plan (Chapter 3) indicated that a few Member States routinely collected displacement and migration-relevant data as a part of some aspect of their national health information datasets. The depth and comprehensiveness of these data need to be evaluated to be used for evidence-informed policy-making. Additionally, methodologies and terminologies used for migrant populations differ among Member States, and data and indicators for some migrant populations and refugees may not be recorded or monitored similarly. The implications and consequences of non-uniform terminology can be important. It complicates the international collection and analysis of comparable information for refugee and migrant populations and can impede the analysis of programme effectiveness between locations using different terminologies. It has been suggested that national health information systems, in addition to public health surveillance systems, should collect standardized and disaggregated data for all refugees and migrants *(12)*. Specific datasets of comparable nature are required to support regional and national health policy and planning, and common and comparable definitions are required to improve understanding of the use of health services by refugees and migrants, identify needs and areas for targeted interventions, and support evidence-informed policy development in regional refugee and migrant health *(13)*. Standardization and coordination of migration-related indicators and data elements across and between health information and social services systems of Member States is a complex undertaking but should be considered for the establishment of a common monitoring system based on agreed variables and indicators. The development of a global monitoring mechanism based on commonly agreed variables/indicators is highly recommended.

Maintaining traction and enhancing political leadership

Many of the recommendations summarized here are not new and have been formulated since the late 2000s. Yet no significant traction has been found in general in advancing a comprehensive refugee and migrant health agenda. The international community has now firmly prioritized displacement and migration as an essential matter for cooperation and concerted action, and Member States of the WHO European Region have shown foresight and leadership in setting common goals through a regional strategy. This should further enhance intercountry and interregional cooperation in view of the elaboration of a WHO global action plan in 2019. The 2030 Agenda and various ongoing migration and development debates offer opportunities to the health sector to enlist political commitment, accountability and resources. It is essential to maintain momentum and use all available platforms to mainstream refugee and migrant health and thus achieve incremental and cumulative results.

The Migration and Health programme: a collaborative way forward

The WHO Regional Office for Europe will continue to support the implementation of the Strategy and Action Plan and assist countries in filling potential gaps in health service delivery, working with Member States, other United Nations agencies (e.g. ILO, IOM, UNHCR, the Joint United Nations Programme on HIV and AIDS and the United Nations Population Fund), health professionals, academia, civil society and the private sector as required. This includes training of health care staff, provision of technical assistance, carrying out joint public health and health system assessment missions, and provision of policy recommendations using the WHO toolkit to prepare for large influxes of refugees and migrants.

Through its Knowledge Hub on Migration and Health, the WHO Regional Office for Europe will continue to support Member States and partners in building expertise and competences, sharing good practices and formats, developing technical guidance, orienting operational research, and devising innovative models and solutions to emerging refugee and migrant health challenges. The way ahead is still long and the undertaking is complex, yet the ground-breaking endeavours ongoing in the Region based on a collective awareness of these challenges is contributing to adjusting global health strategies and visions to the reality of a world on the move.

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The Migration and Health programme (MIG)

The Migration and Health programme, the first fully-fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

National Institute for Health, Migration and Poverty (INMP)

The National Institute for Health, Migration and Poverty is an Italian public institution under the authority of the Ministry of Health. It was established in 2007 to address social and health inequalities affecting vulnerable populations, among which are migrants and poor people. The Institute is the Reference Centre of the National Network for Social and Health Care Issues Related to Migrant Populations and Poverty as well as the National Centre for Transcultural Mediation for the Social and Healthcare Sector. Its mission is to develop and share with the Italian regions innovative models to counteract health inequalities and facilitate access for disadvantaged people to the National Health Service, ensuring them high-quality health care.

REPORT ON THE HEALTH OF REFUGEES AND MIGRANTS IN THE WHO EUROPEAN REGION – NO PUBLIC HEALTH WITHOUT REFUGEE AND MIGRANT HEALTH

Almost one in 10 people in the WHO European Region is currently an international migrant. Finding work is a major reason why people migrate internationally, although violence, conflict, natural disasters and human rights abuses are also contributors. Displacement and migration are social determinants of health affecting the health of refugees and migrants. The WHO Regional Office for Europe has taken the lead in assisting Member States in promoting refugee and migrant health and addressing the public health aspects of their health. The Regional Office established the Migration and Health programme specifically for this purpose. Gaining an overview of the health status of refugees and migrants and health system response is paramount in achieving the Sustainable Development Goals and in ensuring universal health coverage, and is in line with the Health 2020 framework. This report, the first of its kind, creates an evidence base with the aim of catalysing progress towards developing and promoting migrant-sensitive health systems in the 53 Member States of the WHO European Region and beyond. This report seeks to illuminate the causes, consequences and responses to the health needs and challenges faced by refugees and migrants in the Region, while also providing a snapshot of the progress being made across the Region. Additionally, the report seeks to identify gaps that require further action through collaboration, to improve the collection and availability of high-quality data and to stimulate policy initiatives. The report is a much-needed boost for Member States and other stakeholders to ensure high-quality health care for all.

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